Health and Wellness

Annual Report
2011 – 2012

Alberta

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Health and Wellness

Annual Report
2011 – 2012

CONTENTS

Preface 1

Minister's Accountability Statement 2

Message from the Minister 3

Management's Responsibility for Reporting 5

Results Analysis 6
- **Ministry Overview** 6
- **Review Engagement Report (Auditor General's Report)** 9
- **Performance Measures Summary Table** 10
- **Discussion and Analysis of Results** 12
- **Ministry Expense by Function** 39
- **Ministry Financial Highlights** 39

Financial Information 43
- **Ministry Financial Statements** 43
- **Department Financial Statements** 71
- **Ministry Unaudited Information** 99
- **Health Authority Financial Statement Highlights** 103
- **Alberta Health Services Financial Statements** 105
- **Health Quality Council of Alberta Financial Statements** 165

Ministry Contacts 185

Preface

The Public Accounts of Alberta are prepared in accordance with the *Financial Administration Act* and the *Government Accountability Act*. The Public Accounts consist of the annual report of the Government of Alberta and the annual reports of each of the 21 ministries.

The annual report of the Government of Alberta contains ministers' accountability statements, the consolidated financial statements of the province and *Measuring Up* report, which compares actual performance results to desired results set out in the government's strategic plan.

On October 12, 2011, the government announced new ministry structures. The 2011 – 2012 ministry annual reports and financial statements have been prepared based on the October 12, 2011 ministry structure.

This annual report of the Ministry of Health and Wellness contains the minister's accountability statement, the audited consolidated financial statements of the ministry and a comparison of actual performance results to desired results set out in the ministry business plan. This ministry annual report also includes:

- **the financial statements of entities making up the ministry including the department of Health and Wellness, and provincial agencies for which the Minister is responsible,**
- **other financial information as required by the *Financial Administration Act* and *Government Accountability Act*, either as separate reports or as a part of the financial statements, to the extent that the ministry has anything to report; and financial information relating to trust funds**

For financial information relating to Alberta Health Services, which is accountable to the Minister of Health and Wellness, please visit the Alberta Health Services website at www.albertahealthservices.ca

On May 8, 2012, the government announced a cabinet restructure. As a result, the Ministry of Seniors was disestablished and certain programs and services as prescribed by Order in Council 155/2012 were transferred to the Ministry of Health and Wellness. The Ministry was renamed as "Ministry of Health". This most recent restructuring will be reflected in the 2012 – 2013 Ministry Annual Report.

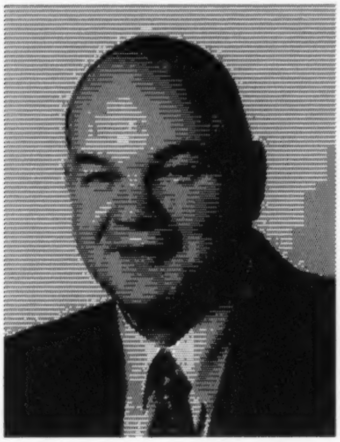
Minister's Accountability Statement

The ministry's annual report for the year ended March 31, 2012, was prepared under my direction in accordance with the *Government Accountability Act* and the government's accounting policies. All of the government's policy decisions as at June 18, 2012 with material economic or fiscal implications of which I am aware have been considered in the preparation of this report.

[original signed by]

Honourable Fred Horne
Minister of Health

Message from the Minister



Since my appointment as Minister in October 2011, I have been working to fulfill my mandate to ensure Alberta's health care system is responsive, integrated and accountable to Albertans. This means working in partnership with health care providers and Albertans to strengthen our public health system and keep Albertans healthy.

This past year we have seen significant accomplishments and improvements to the health system. We must continue to build on these successes as much work remains to be done.

Providing reliable health information and promoting wellness
Giving Albertans reliable health information and promoting wellness was an important activity in 2011 – 2012. On May 2011, we launched MyHealthAlberta, the first phase of a personal health portal that links Albertans to trusted online health care information. Once complete, the portal will give Albertans secure access to their personal health information through the province's electronic health record system.

Government also recognized the work of Alberta food producers and researchers who produce healthy food products, and honored outstanding healthy workplaces in the province through the Premier's Award for Healthy Workplaces.

Primary care services
Our focus on primary care is about improving access to services and making it easier for Albertans to get the care they need. Announced in March, the first three Family Care Clinic pilot projects will open in April in Edmonton, Calgary and Slave Lake. Family care clinics will help to evolve our province's primary care system by improving access in underserved areas, supporting Albertans with chronic disease and using a health care team approach to providing comprehensive primary health services under one roof.

Investing in services for children
Nearly 28,000 pediatric emergency department visits were made to the Stollery Children's Hospital in 2011 — more than double the 12,000 visits recorded when the emergency department opened 12 years ago. To meet these growing demands, a new emergency department at Stollery was completed in January. The renovation provides a separate entrance, triage area and waiting room for patients and their families, as well as more space for pediatric emergency physicians and staff to work in.

An additional 14 new neonatal intensive care beds were also announced in January for the Alberta's Children's Hospital to respond to the increasing number of children from Calgary and southern Alberta needing pediatric intensive care.

Care for seniors, continuing care
As our population ages, designing efficient care for seniors is vital. Two Affordable Supportive Living Initiative projects in Red Deer and Calgary were launched to demonstrate a new aging-in-place continuing care centre model. By 2014, 100 new continuing care spaces will be in place in both locations. This new model will provide multiple levels of care in one setting that will allow individuals and couples to stay in one place.

Expanded benefits for Albertans with diabetes
People with diabetes incur higher medical costs to manage their health. To help reduce this financial burden, government announced expanded funding of diabetic supplies through AHW supplementary health/drug plans. Government also added Lantus and Levemir, two long acting insulins, to the Drug Benefit List.

This expanded support for insulin-treated diabetics is part of government's work to ensure Albertans have the best options to stay healthy and enjoy the highest quality of life.

Reducing sexually transmitted infection rates

Over the past decade, Alberta experienced a sharp rise in rates of sexually transmitted infections (STI). The province had an ongoing outbreak of syphilis since 2007, and our rate of infants dying from congenital syphilis were the highest in Canada during the past few years.

An aggressive five-year province wide strategy was launched in May 2011 to reduce STI rates through education, awareness, enhanced testing and the hiring of more staff. Our bold and unconventional public awareness campaign drew national attention and generated a 17 per cent increase in the number of people visiting Alberta STI clinics.

Work on our five-year strategy has helped us to drive STI rates down. Alberta's rates for new cases of STI fell in 2010, the first decrease since 2004, and rates for new cases of HIV and AIDS also continued to decrease for a second straight year. The lower rates indicates good progress is being made on the province's 2011 – 2016 STI strategy and action plan that was announced in May 2011.

Quality assurance in health

In November, I was pleased to announce that Alberta was joining the Health Council of Canada, an independent national agency that reports on the progress of health care renewal. Alberta's membership in the council will help strengthen partnerships with other provinces and allow us to collaborate effectively on key health care strategies.

In December, I ordered an examination of medical quality assurance processes on diagnostic imaging and pathology tests. I want to ensure that system-wide checks and balances to prevent errors are in place, and are working effectively.

The Legislative Assembly passed the Health Quality Council of Alberta Act in December, giving the Health Quality Council of Alberta (HQCA) greater authority and independence to assess patient safety issues and conduct a health system inquiry.

Government accepted 21 recommendations made by the HQCA health review in February. I also asked that HQCA conduct a review of emergency medical services, and that the Council establish a public inquiry into allegations of queue jumping. A task force on health system governance and clarifying roles with respect to the College of Physicians and Surgeons will also be undertaken by government.

Moving forward

These are just a few highlights of the many activities and tremendous work that was undertaken this year.

More work lies ahead in the areas that matter most to Albertans: improving access to primary care services and reducing wait times in emergency rooms and for crucial surgeries and procedures. We will also continue to implement a provincial addiction and mental health strategy, as well as design a better range of choices for seniors who need continuing care and support in their communities.

I look forward to building a more inclusive and collaborative partnership with Albertans and health care providers to deliver the best possible health care system and health outcomes for our province.

[original signed by]

Honourable Fred Horne
Minister of Health

Management's Responsibility for Reporting

The Ministry of Health and Wellness includes:

The executives of the individual entities within the Ministry have the primary responsibility and accountability for the respective entities. Collectively, the executives ensure the Ministry complies with all relevant legislation, regulations and policies.

Ministry business plans, annual reports, performance results and the supporting management information are integral to the government's fiscal and strategic plan, annual report, quarterly reports and other financial and performance reporting.

Responsibility for the integrity and objectivity of the consolidated financial statements and performance results for the Ministry rests with the Minister of Health. Under the direction of the Minister, I oversee the preparation of the Ministry's annual report, including consolidated financial statements and performance results. The consolidated financial statements and the performance results, of necessity, include amounts that are based on estimates and judgments. The consolidated financial statements are prepared in accordance with Canadian public sector accounting standards. The performance measures are prepared in accordance with the following criteria:

- Reliability — information used in applying performance measure methodologies agrees with underlying source data for the current and prior years' results.
- Understandability — the performance measure methodologies and results are presented clearly.
- Comparability — the methodologies for performance measure preparation are applied consistently for the current and prior years' results.
- Completeness — goals, performance measures and related targets match those included in the Ministry's Budget 2011.

As Deputy Minister, in addition to program responsibilities, I am responsible for the Ministry's financial administration and reporting functions. The Ministry maintains systems of financial management and internal control which give consideration to costs, benefits, and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- provide information to manage and report on performance;
- safeguard the assets and properties of the Province under Ministry administration;
- provide Executive Council, the President of Treasury Board and Minister of Finance and the Minister of Health information needed to fulfill their responsibilities; and
- facilitate preparation of Ministry business plans and annual reports required under the *Government Accountability Act.*

In fulfilling my responsibilities for the Ministry, I have relied, as necessary, on the executive of the individual entities within the Ministry.

[original signed by]

Marcia Nelson
Deputy Minister of Health
June 7, 2012

Results Analysis

Ministry Overview

The ministry's focus and role is the development of strategic policy, setting standards and regulations, ensuring accountability, and pursuing innovations on behalf of Albertans. Alberta Health Services delivers health services in response to direction received from the ministry.

Alberta Health Services' specific plans for delivering health services, and its priorities for the health system, can be found in its Strategic Direction Plan, which can be accessed at www.albertahealthservices.ca.

Our Vision: *Healthy Albertans in a Healthy Alberta*

The achievement of this vision is everybody's responsibility. The Ministry of Health and Wellness plays a leadership role in achieving this vision through our mission, core business and goals.

Our Mission: *Health and Wellness sets policy and direction to lead, achieve and sustain a responsive, integrated and accountable health system.*

The ministry fulfills this mission through its core business, leadership and governance, which is supported by corresponding business plan goals.

Core Business: *Leadership and governance.*

Goal 1 – Effective health system accountability.

Goal 2 – Strengthened public health and healthy living.

Goal 3 – Appropriate health workforce utilization.

Goal 4 – Excellence in health care.

Health and Wellness (HW) leads and participates in the continuous improvement of the health system by promoting innovation and efficiency. The ministry is committed to a sustainable and patient-focused approach to meet the present and future needs of Albertans. All divisions have key activities related to the health system and work together to achieve department's goals and priority initiatives.

Health Policy and Service Standards (HPSS)

Facilitates change in the health system by developing health system policy and (including access, continuing care, quality and sustainability) and works with federal/provincial/territorial health departments on current and emerging issues.

Health Information Technology and Systems (HITS)

Is responsible for the planning, execution and oversight of information management and technology systems that support the enterprise strategic goals of the ministry and the health system. This included leading ministry and health system executives in identifying or renewing business development opportunities within the ministry, across the GoA enterprise, or with health system organizations in Alberta.

Health Workforce (HWF)

Promotes innovative approaches and strategies to ensure there is a balanced workforce to meet Alberta's health needs in a fiscally sustainable manner, along with Alberta Health Services, physicians, pharmacists, professional college, professional associations and other partners.

Financial Accountability (FA)

Develops performance measurement, planning and accountability frameworks to measure, monitor and report on progress of the health system and ministry. It also provides leadership on internal and external funding allocations, financial accountability, the cost of health services, and fiscal planning. It conducts analytical studies and works with the Auditor General of Alberta on fiscal and performance results reporting matters.

Community and Population Health (CPH)

Provides strategic direction and leadership in the development of provincial policies, strategies and standards in health promotion; wellness; disease prevention and control; public health surveillance and population health assessment; environmental health; addiction; mental health and emergency preparedness.

Corporate Support (CS)

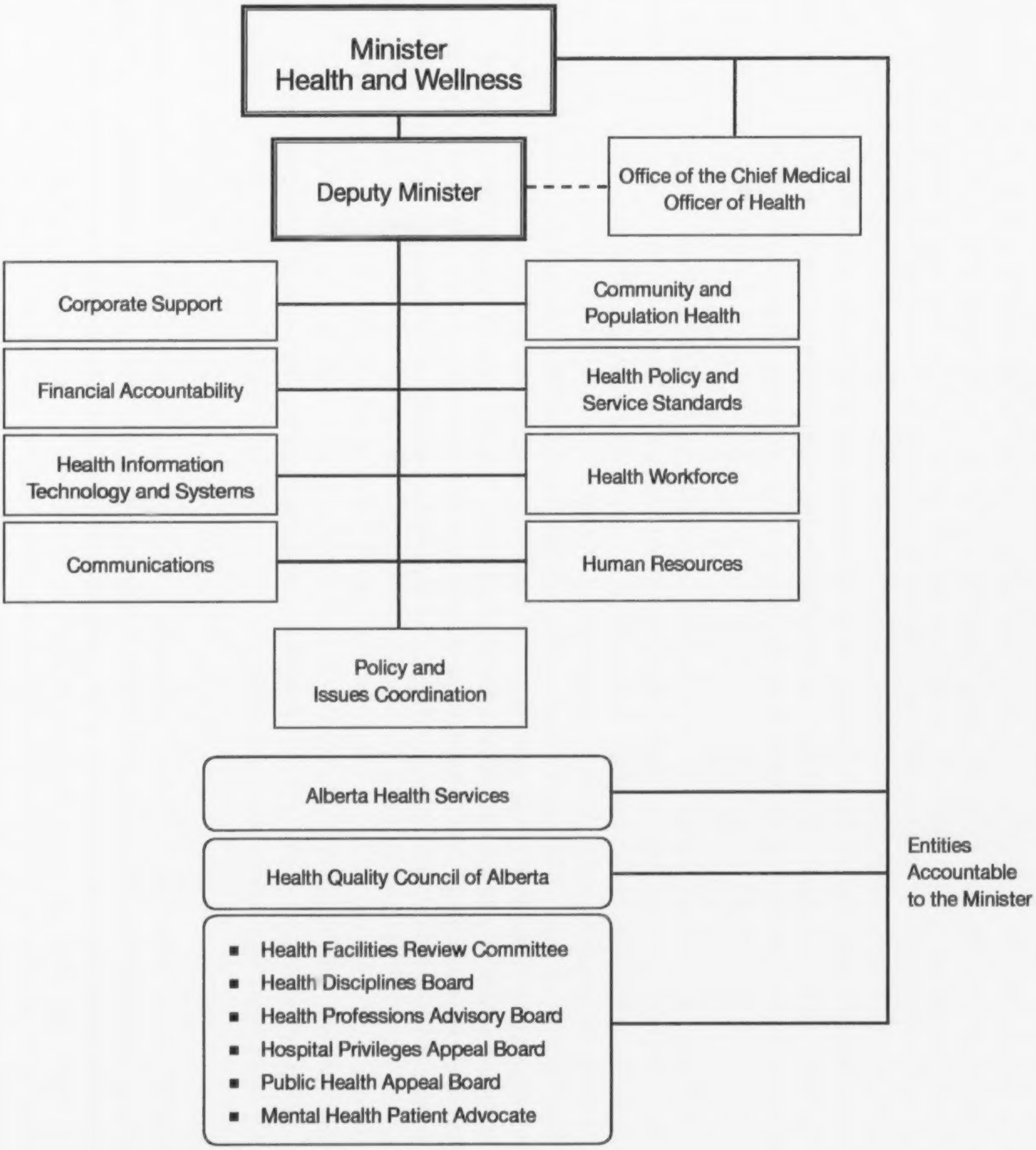
Responsible for providing legal advice and support, health claims processing, governance and administration of Alberta Health Care Insurance Plan, compliance monitoring, enterprise-wide risk management and other administrative functions required to enable the department to fulfill its mandate.

Policy and Issues Coordination (PIC)

Provides overall leadership in identifying strategic priorities that are key to achieving Ministry and GoA goals. The division oversees the identification and analysis of daily and emerging issues and liaises with the Executive Team, Minister's Office, Alberta Health Services and other stakeholders as required to formulate coordinated responses.

Ministry of Health and Wellness Organization

(For the year ended March 31, 2012)


Minister
Health and Wellness
Deputy Minister
Office of the Chief Medical Officer of Health
Corporate Support
Community and Population Health
Financial Accountability
Health Policy and Service Standards
Health Information Technology and Systems
Health Workforce
Communications
Human Resources
Policy and Issues Coordination
Alberta Health Services
Health Quality Council of Alberta
Health Facilities Review Committee
Health Disciplines Board
Health Professions Advisory Board
Hospital Privileges Appeal Board
Public Health Appeal Board
Mental Health Patient Advocate
Entities Accountable to the Minister

AUDITOR
GENERAL
Alberta

Review Engagement Report

To the Members of the Legislative Assembly

I have reviewed the performance measures identified as "Reviewed by Auditor General" in the *Ministry of Health and Wellness's 2011-12 Annual Report*. The reviewed performance measures are the responsibility of the Ministry and are prepared based on the following criteria:

- Reliability - information used in applying performance measure methodologies agrees with underlying source data for the current and prior years' results.
- Understandability - the performance measure methodologies and results are presented clearly.
- Comparability - the methodologies for performance measure preparation are applied consistently for the current and prior years' results.
- Completeness - goals, performance measures and related targets match those included in the Ministry's Budget 2011.

My review was made in accordance with Canadian generally accepted standards for review engagements and accordingly, consisted primarily of enquiry, analytical procedures and discussion related to information supplied to me by the Ministry.

A review does not constitute an audit and, consequently, I do not express an audit opinion on the performance measures. Further, my review was not designed to assess the relevance and sufficiency of the reviewed performance measures in demonstrating Ministry progress towards the related goals.

Based on my review, nothing has come to my attention that causes me to believe that the "Reviewed by Auditor General" performance measures in the Ministry's 2011-12 Annual Report are not, in all material respects, presented in accordance with the criteria of reliability, understandability, comparability, and completeness as described above.

[Original signed by Merwan N. Saher, FCA]

Auditor General

May 25, 2012

Edmonton, Alberta

Performance measures reviewed by the Auditor General are noted with an asterisk (*)
on the Performance Measures Summary Table

Performance Measures Summary Table

Goals/Performance Measure(s)	Prior Years' Results				Target	Current Actual
Core Business : Leadership and governance						
1. Effective health system accountability						
1.a* Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year	58% 2005/2006	60% 2007/2008	61% 2009/2010	67% 2010/2011	**65%**	62% 2011/2012
2. Strengthened public health and healthy living						
2.a Smoking: Prevalence of smoking **						
• Alberta youth aged 12 to 19 years	11% 2005	10% 2007	12% 2008	12% 2009	**9%**	13% 2010
• Young adults aged 20 to 24 years	33% 2005	30% 2007	26% 2008	25% 2009	**24%**	30% 2010
2.b Influenza immunization: Percentage of Albertans who have received the recommended seasonal influenza immunization***						
• Seniors aged 65 years and over	60% 2007/2008	58% 2008/2009	56% 2009/2010	59% 2010/2011	**75%**	61% 2011/2012
• Children aged 6 to 23 months	64% 2007/2008	43% 2008/2009	16% 2009/2010	25% 2010/2011	**75%**	29% 2011/2012
• Residents of long term care facilities	94% 2007/2008	95% 2008/2009	91% 2009/2010	90% 2010/2011	**95%**	91% 2011/2012
2.c Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)***						
• Chlamydia	329 2007	344.7 2008	379.3 2009	356.1 2010	**330**	371.2 2011
• Gonorrhea	64 2007	60.8 2008	43.8 2009	32.5 2010	**50**	39.6 2011
• Syphilis	7.3 2007	7.0 2008	7.7 2009	4.7 2010	**6.5**	2.4 2011
3. Appropriate health workforce utilization						
3.a Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network**	—	—	55% 2008/2009	60% 2009/2010	**68%**	67% 2010/2011
4. Excellence in health care						
4.a* Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	13% 2005/2006	10% 2007/2008	9% 2009/2010	12% 2010/2011	**9%**	11% 2011/2012

	Goals/Performance Measure(s)	Prior Years' Results				Target	Current Actual
4.b	Continuing care:						
	Number of persons waiting in an acute care hospital bed for continuing care	645 2007/2008	754 2008/2009	707 2009/2010	471 2010/2011	**375**	467 2011/2012
	Number of persons waiting in the community for continuing care	—	1,065 2008/2009	1,039 2009/2010	1,110 2010/2011	**900**	1,002 2011/2012
4.c	Wait time for hip replacement surgery: 90th percentile wait time in weeks	36 2007/2008	36 2008/2009	35 2009/2010	39 2010/2011	**27**	40 2011/2012
4.d	Wait time for knee replacement surgery: 90th percentile wait time in weeks	49 2007/2008	46 2008/2009	49 2009/2010	49 2010/2011	**35**	48 2011/2012
4.e	Wait time for cataract surgery: 90th percentile wait time in weeks	28 2007/2008	30 2008/2009	42 2009/2010	47 2010/2011	**30**	35 2011/2012
4.f	Alberta Netcare: Number of care providers accessing Alberta Netcare**	29,110 2007/2008	34,200 2008/2009	39,866 2009/2010	— 2010/2011	**45,229**	— 2011/2012
4.g	Physician utilization of electronic medical records: Percentage of community physicians using the Electronic Medical Record in their clinic	45% 2007/2008	46% 2008/2009	46% 2009//2010	53% 2010/2011	**60%**	57% 2011/2012
4.h	Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta	29.3% 2007	32.8% 2008	35.1% 2009	38.8% 2010	**38%**	41.9% 2011

*** Indicates Performance Measures that have been reviewed by the Office of the Auditor General**
The performance measures indicated with an asterisk were selected for review by ministry management based on the following criteria established by government:

- Enduring measures that best represent the goal and mandated initiatives.
- Measures for which new data is available.
- Measures that have well established methodology.

****Note:**
Measure 2.a. Smoking: Prevalence of smoking — Result for 2011 is not available as of June 30, 2012. Results for the 12 – 19 age group in 2005, 2007, 2008 and 2009 are restated due to the change in dataset from the Canadian Community Health Survey (CCHS) CANSIM Table 105-0501 to the Alberta Share File of the CCHS.

Measure 3.a. Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network — Result for 2011 – 2012 is not available as of June 30, 2012.

Measure 4.f. Alberta Netcare: Number of care providers accessing Alberta Netcare. During 2010 – 2011 and 2011 – 2012, some older systems that were a source for reporting this measure were retired and the surviving systems are now feeding a new reporting system. The methodology to gather and report the counts under the new system, as provided by Alberta Health Services, is still in progress for validation. Data available for 2010 – 2011 and 2011 – 2012 are not reliable and are not comparable to prior years. Therefore, results for 2010 – 2011 and 2011 – 2012 are not reported in the 2011 – 2012 annual report.

*****Note:**
Measure 2.b Influenza immunization — In order to meet 2011 – 2012 reporting deadlines, results for influenza immunization of seniors and children aged 6 to 23 months are based on data up to March 31, 2012, which may be earlier than the end of the seasonal influenza season. Caution should be used in comparing the 2010 – 2011 and 2011 – 2012 result for children aged 6 to 23 months with results from prior years, due to changes in the methodology used to calculate the percentage of children aged 6 to 23 months who have received the recommended seasonal influenza immunization.

Measure 2.c Sexually transmitted infections: Rate of newly reported infections (per 100,000 population) Chlamydia; Gonorrhea; Syphilis. The 2011 results are preliminary and accurate as of March 31, 2012.

For more detailed information, see the Performance Measures — Data Sources and Methodology section of the annual report, pages 32 to 38.

Discussion and Analysis of Results

GOAL 1: Linked to Core Business – Leadership and governance

Effective health system accountability

Sound governance mechanisms are essential for health system accountability and for the system to operate within its financial limits while meeting the needs of Albertans. A strong, broad based accountability and reporting structure enables the coordination of efforts, transparent reporting and tangible progress in providing access to a broad range of quality health services. In addition, Albertans are provided with quality customer service by efficient administration of the Alberta Health Care Insurance Plan and monitoring compliance with regulations, directives and health standards.

Achievements

Governance and Accountability of the Health System

- The Ministry has accepted the February 2012 HQCA recommendation to establish a task force to "delineate the lines of authority, roles and responsibilities, and accountabilities between the Minister, Health and Wellness, Alberta Health Services and the medical profession." The results of this task force will further inform mechanisms to ensure effective governance and accountability.
- Further, in collaboration with Alberta Health Services and the Health Quality Council of Alberta, the Ministry has formally approved the definitions of publicly reported performance measures. These performance measures are included in the Alberta Health Services' Health Plan, as approved by the Minister, and form the basis of Alberta Health Services' quarterly publication of performance results.

Health Capital Planning

- Alberta Infrastructure is now delivering capital projects with values over $5 million. This change, made last year, has required the development of new processes and procedures. Throughout 2011 – 2012 Health and Wellness, Alberta Infrastructure and Alberta Health Services have been developing the new processes, including preparing a memorandum of understanding and a capital manual. The capital manual is a capital procedure/process manual outlining the new capital delivery process.
- Health and Wellness leads the capital planning process by submitting projects and requesting funding through government's annual capital planning process. Once projects are approved, Health and Wellness reviews and approves the project planning documents, including the needs assessments, business cases and functional programs. This review ensures projects are in alignment with Ministry and government goals and objectives, including Alberta's 5-Year Health Action Plan. These planning reviews are currently underway for the approved health facilities for communities in Medicine Hat, Lethbridge, Grande Prairie, Edson and High Prairie.
- The following are the major capital accomplishments completed in 2011 – 2012 which provide the infrastructure support for the health system to achieve the strategies and goals outlined in *Alberta's 5-Year Health Action Plan*:
  - Opened the new 120-bed long-term care Stony Plain Care Centre;
  - Completion of the new replacement Fort Saskatchewan Community Hospital in the spring of 2012;
  - In Edmonton, expanding and renovating the emergency department at the Stollery Children's Hospital was completed; and
  - The Walter A. "Slim" Thorpe Recovery Centre opened in Lloydminster.

- Alberta's 5-Year Health Action Plan also sets a target for 2,300 additional continuing care spaces by March 2012. The capital funding for these additional spaces has primarily been provided through the Affordable Supportive Living Initiative managed by Alberta Seniors and Community Supports. However, the Health Capital Budget also includes projects or funding to increase continuing care capacity. One example is the Stony Plain Care Centre noted above. By March 31, 2012 approximately 2,216 new continuing care spaces have been created.

Alberta's Health Research and Innovation Strategy

- The Alberta Health Research and Innovation Strategy (AHRIS) Implementation Oversight Committee was established and Terms of Reference were developed. The AHRIS Reporting and Evaluation Framework was established.

Key Performance Measure and Results

MEASURE 1.A Satisfaction with health care services received

This measure identifies Albertans' satisfaction with health care services personally received in Alberta within the past year. Satisfaction with health care services is dependent on several factors such as visits to physicians, visits to the emergency department, use of home care services, external influences such as perception and experience of others and information received. Satisfaction is an important measure as it supports quality improvement and the objective of delivering high quality patient centered care.

The Health Quality Council of Alberta (HQCA) 2012 survey of Albertans aged 18 and older found that 62 per cent were satisfied or very satisfied with health care services received in Alberta within the past year. This result is significantly down from 67 per cent in 2010 – 2011, and under the target of 65 per cent.

This past year has had an unprecedented number of inquiries and news releases regarding health system quality which may have impacted overall satisfaction.

The HQCA was asked to review multiple matters respecting patient safety and health service quality:

- *Emergency medical services (EMS) response times and emergency department (ED) wait times* (currently underway, to be completed October, 2012);
- *Quality of anatomical pathology specimen preparation and interpretation* (currently underway, to be completed July, 2012);
- *Quality of care and safety of patients requiring access to emergency department care and cancer surgery and the role of physician advocacy* (final report February, 2012); and
- *Safety implications for patients requiring medevac services to and from the Edmonton international airport* (final report May, 2011).

In response to interpretation errors in diagnostic imaging, the Minister announced a medical assurance project that will assure a high quality of medical services provided to Albertans (December, 2011). Also, Cabinet initiated a public inquiry into preferential access to publicly funded health services (February, 2012).

These reports have created greater awareness and attention to potential concerns in Alberta's health system. Many issues that have been, or are currently being addressed, have been given significant attention such as cancer patient wait times, long term care beds and queue jumping. There is a greater awareness of systemic issues in the health system.

Satisfaction with health care services received

	2005/ 2006	2007/ 2008	2009/ 2010	2010/ 2011	2011/ 2012	Target 2011/2012
Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year.	58%	60%	61%	67%	62%	**65%**

Source: Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans (2006, 2008, 2010, 2012). Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011).

GOAL 2: Linked to Core Business – Leadership and governance

Strengthened public health and healthy living

Health is comprised of physical, mental, emotional, social and spiritual dimensions. There is a growing realization that good health depends on the efforts and commitment of individuals, families, entire communities and society as a whole. The ministry will continue current partnerships and will form new broad based partnerships with other ministries and governments, community agencies, businesses and industry, universities and health service providers to build healthy communities, healthy environments and to support healthy choices.

Achievements

Emergency Preparedness Planning

- An All-Hazards Health Emergency Management Approach (the Approach) has been developed to provide common principles and concepts to use in planning for and responding to different types of emergency events with key stakeholders such as Alberta Health Services. Development of an All-Hazards Health Emergency Management Response Plan using the Approach as its foundation has commenced. The Approach defines common roles and responsibilities and identifies integration points for working together during emergencies. The Approach is intended to reduce duplication and promote efficiencies.

Environmental Public Health Strategic Plan

- Development of an environmental public health strategic plan has been initiated. The purpose of the plan is to clearly set out Health and Wellness (AHW) environmental public health directions and priorities; clarify roles, responsibilities, and relationships amongst numerous stakeholders; and strengthen the interface between AHW and other government ministries whose responsibilities have the potential to impact on human health.

Provincial Communicable Disease and Outbreak Management Strategy

- In 2011 – 2012, Health and Wellness and Alberta Health Services worked together to design the first phase of the Communicable Disease and Outbreak Management (CDOM) Information System. This information system will allow for close to real time reporting of communicable diseases, which will enable quicker surveillance, improved communication between public health service providers and action to effectively monitor and manage communicable diseases, prevent disease outbreaks and protect the health of Albertans. The CDOM information system will be expanded and enhanced to include additional phases over the next three to five years.

Addiction and Mental Health Strategy Implementation

- *Creating Connections: Alberta's Addiction and Mental Health Strategy* was released on September 12, 2011 by Health and Wellness and Alberta Health Services. The Strategy sets the direction for addiction and mental health services in Alberta for the next five years and will reduce the prevalence of addiction, mental health problems and mental illness in Alberta through health promotion and prevention activities and providing quality assessment, treatment and supportive services when needed. Health and Wellness, Alberta Health Services and partnering ministries are currently implementing the *Strategy*. Task teams have begun work on implementing Year One Priority Initiatives.

Action on Wellness

- The International Action on Wellness Symposium was hosted in Banff, October 11 – 13, 2011. This high quality event was attended by approximately 500 delegates from each province as well as international delegates with the ability to impact the wellness of Albertans and others where they live, learn, work and play.

Aboriginal Health Strategy

- The *Aboriginal Wellness Strategy*, based on the wisdom and perspectives of Alberta's Aboriginal people is being developed by Alberta's First Nation, Métis and Inuit communities, Health and Wellness, Alberta Health Services, Health Canada and Aboriginal organizations. Establishing partnerships for action based on an Aboriginal perspective of health marks considerable achievement of progress towards a shared commitment by multiple stakeholders to move forward to improve Aboriginal wellness across Alberta.
- A steering committee was set up in January 2011 to guide and advise the development of the strategy. The steering committee engages management level representatives from federal and provincial departments, Aboriginal stakeholder organizations and AHS. The steering committee meets monthly and at the call of the chair.

Alberta Sexually Transmitted Infections and Blood Borne Pathogens Strategy

On May 24, 2011, the *Alberta Sexually Transmitted Infections (STI) and Blood Borne Pathogens (BBP) Strategy and Action Plan 2011 – 2016* was released. The 5-year strategy and action plan focuses on reducing rates of STI and BBP through education, awareness, enhanced testing and the hiring of more staff. The strategy also aims to minimize the health, social and economic consequences of these diseases.

- **Awareness Campaign** — As part of the strategy, a province wide $2 million awareness campaign to educate the public about the risks of syphilis and other sexually transmitted infections called "Don't You Get It" was released in May and June 2011. Part 2 of the campaign called "PlentyofSyph" was launched in early June 2011. It included an interactive website, television and radio advertisements. Visits for testing to STI clinics saw an increase of 17 per cent in June. The two campaigns received 7 ACE Awards from the Advertising Club of Edmonton which recognize excellence based on international standards.
- **Cervical Cancer Screening Enhancement** — In October 2011, the Alberta Cervical Cancer Screening Program expanded to become a province-wide program by including an additional 680,000 women age 21 to 69 that live in the North, Edmonton and Central zones. This program supports eligible women to have Pap tests regularly and to follow-up on any abnormal results by sending them letters related to cervical cancer screening.

Key Performance Measures and Results

Measure 2.A Smoking

Tobacco use is the leading cause of preventable disease and death in Canada. Tobacco use has no safe level of consumption and is highly addictive. In Alberta, tobacco use is responsible for over 3,000 deaths each year.

The *Alberta Tobacco Reduction Strategy* seeks to prevent tobacco use among youth, protect Albertans from second-hand smoke and help current tobacco users quit. The prevalence of smoking among Alberta youth and young adults are measures of the Strategy's success with tobacco prevention, protection and cessation.

The prevalence of smoking among Albertans aged 12 to 19 has been increasing slightly every year since 2007; the slight increase in smoking rates continues to be observed from 2009 to 2010. In 2010, the smoking rate for youth aged 12 to 19 in Alberta was 12.8 per cent, which is an increase from 12.3 per cent in 2009. This increase is not statistically significant, and may be the result of statistical variability within the process or measurement of the Canadian Community Health Survey.

The 2011 – 2012 performance target of 9 per cent as the smoking rate among Albertans aged 12 to 19 was not achieved. This shortcoming may be due to the need for more comprehensive youth tobacco reduction initiatives.

Health and Wellness and Alberta Health Services implemented initiatives in the 2011 – 2012 fiscal year related to Albertans 12 to 19 years of age, as follows:

- The Provincial Advisory Committee on Tobacco met three times during 2011 – 2012 and was instrumental in helping to develop a draft version of a renewed Alberta Tobacco Reduction Strategy. It is proposed that the renewed Strategy will have a strong focus on youth and young adult tobacco prevention, protection and cessation.
- School-based tobacco reduction programs continued to be offered across Alberta.
- Tobacco reduction counsellors across the province continued to work within schools to encourage tobacco prevention.

The smoking prevalence rate for Albertans aged 20 to 24 declined over the 2003 – 2009 period; however, there was an increase in smoking rates from 2009 to 2010. In 2010 the smoking rate for Albertans aged 20 to 24 in Alberta was 30 per cent compared to 25 per cent in 2009. This increase is significantly different from the trend seen during the 2003 to 2009 period.

The 2011 – 2012 performance target of 24 per cent as the smoking rate among Albertans aged 20 to 24 was not achieved. This limitation may be due to the fact that Alberta has not had a sustained tobacco control social marketing.

Health and Wellness and Alberta Health Services implemented initiatives in 2011 – 2012 which impacted Albertans 20 to 24 years of age, as follows:

- Work commenced on the development of a young adult tobacco prevention strategy which is intended to specifically address the unique tobacco reduction needs of this demographic.
- Alberta Health Services' tobacco cessation services were rebranded to AlbertaQuits and three promotional pulses were implemented in an effort to increase call volume to tobacco cessation services. Each promotional pulse resulted in noticeable increases in AlbertaQuits Online website traffic and call volume to the AlbertaQuits Helpline.
- Health professional tobacco cessation training continued to be offered throughout Alberta. In 2011 – 2012, 669 health professionals were trained.
- AlbertaQuits Groups, a group tobacco cessation counselling program, continued to be offered.

- As of June 15, 2011 Champix® (varenicline tartrate) was made available as a benefit to members of the government-sponsored supplementary health plans to assist them in quitting smoking.
- A total of 11 grants were funded which included projects that focused on tobacco prevention, protection, and cessation.
- New health warning messages began to appear on tobacco packages across the province directing Albertans to provincial tobacco cessation services.
- On April 1, 2011 Alberta Health Services implemented the Tobacco and Smoke Free Environments policy which prohibits the use of tobacco products and prevents exposure to second hand smoke at Alberta Health Services sites province wide.

Smoking: Prevalence of smoking among Alberta youth and young adults

	2005	**2007**	**2008**	**2009**	**2010**	**Target 2011/2012**
Prevalence of smoking: Alberta youth 12 to 19 years	11%	10%	12%	12%	13%	**9%**
Young adults aged 20 to 24 years	33%	30%	26%	25%	30%	**24%**

Source: Statistics Canada. Canadian Community Health Survey, Alberta Share File (2005, 2007, 2008, 2009, 2010).

Note: Results for the 12 to 19 age group in 2005, 2007, 2008, and 2009 are restated due to the change in dataset from the Canadian Community Health Survey CANSIM Table 105-0501 to the Alberta Share File of the CCHS.

MEASURE 2.B Influenza immunization

Influenza has a significant seasonal impact on the health of Albertans and tends to be most severe among older Albertans, residents of long term care facilities, infants and young children, and those with certain chronic medical conditions. Hospitalizations for influenza are more likely to occur in seniors and in children 6 to 23 months of age. Influenza illness can cause significant morbidity and mortality in this population and those who are ill can quickly fill acute care hospitals and emergency departments.

Health and Wellness introduced a Universal Influenza Immunization Program in the fall of 2009 in order to improve immunization rates for high risk groups, while also decreasing their risk of contracting the virus.

Uptake by seniors increased by two per cent. This may be due to the increased ability of seniors to access the vaccine from community partners, such as pharmacists, and the increased number of outreach clinics offered by AHS to seniors (e.g. at recreation centres and lodges and "snowbird" clinics in zones).

Improved rates for children six to 23 months of age can be attributed to improved processes for immunization data collection and reporting by AHS as well as immunization pilots at day care centres and school sites.

Influenza immunization: Percentage of Albertans who have received the recommended seasonal immunization

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	Target 2011/2012
Seniors aged 65 and over	60%	58%	56%	59%	61%	**75%**
Children aged 6 to 23 months	64%	43%	16%	25%	29%	**75%**
Residents of long-term care facilities	94%	95%	91%	90%	91%	**95%**

Source: Alberta Health Services Zones, Community Partners, First Nations and Inuit Health, Health Canada (Alberta Region), Health and Wellness Interactive Health Data Application.

***Note:** In order to meet 2011 – 2012 reporting deadlines, results for influenza immunization of seniors and children aged 6 to 23 months are based on data up to March 31, 2012, which may be earlier than the end of the seasonal influenza season. Caution should be used in comparing the 2010 – 2011 and 2011 – 2012 result for children aged 6 to 23 months with results from prior years, due to changes in the methodology used to calculate the percentage of children aged 6 to 23 months who have received the recommended seasonal influenza immunization.

MEASURE 2.C Sexually transmitted infections

Sexually transmitted infections are an important focus for public health surveillance, policy development and public health programming. The diseases resulting from these infections are widespread, have potentially severe. even lethal effects, and carry high social and economic costs.

Chlamydia is the most common notifiable disease in Alberta. It is easily treatable with antibiotics, although if left untreated can cause long-term complications. Gonorrhea is the second most commonly reported sexually transmitted infection in Alberta. Many gonorrheal infections have no symptoms. Evidence of resistance to antibiotics has been increasing; thus prevention is key. Syphilis is a serious infection, It is treatable with antibiotics, though left untreated can cause irreversible organ damage and even death. Congenital syphilis is the vertical transmission of syphilis from an infected mother to her infant. The first case of congenital syphilis in many years was reported in 2002. In 2009 there were 7 cases; in 2011 one case was reported. Since 2002, several of these infants have died while others are severely affected by debilitating long-term physical effects and many of these children will grow up with life-long developmental problems.

The rate of infectious syphilis has decreased. This is a significant achievement and is below the performance target. This can be partly attributed to the *Alberta Sexually Transmitted Infections (STI) and Blood Borne Pathogens (BBP) Strategy and Action Plan 2011 – 2016*. This strategy and action plan focuses on reducing rates of STI and BBP among Albertans. The strategy also aims to minimize the health, social and economic consequences of these diseases.

As part of the strategy, a province-wide awareness campaign to educate the public about the risks of syphilis and other sexually transmitted infections, called "Don't You Get It", was released followed by the campaign called "PlentyofSyph". It included an interactive website, television and radio advertisements. Visit to STI clinics for testing saw an increase of 17 per cent by June 2011.

The rates of both Chlamydia and Gonorrhea have increased. This is likely the result of the increase in testing. This was an expected consequence of the awareness campaign.

Sexually transmitted infections: Rate of newly reported infections (per 100,000 populations)

	2007	2008	2009	2010	2011	Target 2011/2012
• Chlamydia: Rate of newly reported infections (per 100,000 population)	329	344.7	379.3	356.1	371.2	**330**
• Gonorrhea: Rate of newly reported infections (per 100,000 population)	64	60.8	43.8	32.5	39.6	**50**
• Syphilis: Rate of newly reported infections (per 100,000 population)	7.3	7.0	7.7	4.7	2.4	**6.5**

Source: Health and Wellness. CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection).

Note: The 2011 results are preliminary and accurate as of March 31, 2012.

Goal 3: Linked to Core Business – Leadership and governance

Appropriate health workforce utilization

Through various funding programs, collaborations and partnerships, the ministry assures the provision of quality health care services by enhancing the availability and sustainability of the health workforce. Efficient, effective and innovative patient care models can be achieved by leveraging health workforce resources and optimizing utilization of education, skills and experience. It includes new initiatives to increase Alberta's ability to train, recruit and retain health professionals including the recruitment of internationally trained health workers.

Achievements

Primary Health Care System

- **Family Care Clinics** — Three pilot Family Care Clinics were developed and are operational in Edmonton, Calgary and Slave Lake in April 2012. The Family Care Clinics are an innovative way to provide access to comprehensive primary health care services to Albertans when they need it, where they need it, from the most appropriate health provider(s).
- **Primary Care Network (PCN)** — The Wainwright PCN, was launched on April 1, 2011. As of April 1, 2012 there were 40 PCNs operating in the province, which included more than 2,500 family physicians providing primary health care to over 2.8 million Albertans.
- **Entry Level Positions** — Residency capacity in the Departments of Family Medicine at the Universities of Alberta and Calgary were increased in order to train additional family physicians. In March 2012, the University of Alberta allocated 41 per cent of its entry-level residency positions to family medicine (thus maintaining the 41 per cent allocation from March 2011), and the University of Calgary allocated 41 per cent of its entry-level positions to family medicine, an increase from 36 per cent in March 2011. Both universities continue to work towards allocating 45 per cent of entry-level postgraduate residency training positions to family medicine programs.

Improve Access to Clinical Care and Treatment

- **Access Improvement Measures (AIM)** — This program expanded and more family physicians enrolled in 2011 – 2012 and specialists can now enrol too. The program assists physicians and health teams to reduce wait times for patient visits and improve access to health care for Albertans. AIM is a structured, guided and facilitated process to support clinics in implementing improvements in their practices relative to access, efficiency, and clinical care. Clinics that choose to take part in the Alberta AIM Initiative form clinic improvement teams that participate in a series of collaborative learning sessions, returning to their clinics between sessions to test changes in their practices and processes, and measure the results from the changes. As of March 31, 2012, 150 primary care clinics and 79 specialty and/or regional programs involving 770 general practitioners, 434 specialists and 1,043 allied health providers have or are currently participating in the program. For example, in some clinics that participated in AIM sessions, there was a significant reduction in wait times, with primary care clinics reducing average wait times for appointments by six days in some instances.
- **Alternate Relationship Plans (ARPs)** — There are 47 Clinical Alternative Relationship Plans established under the Clinical Alternative Relationship Plan Framework in 2011 – 2012. This plan standardizes the rules governing how physicians are compensated in order to provide innovation in clinical services, enhance physician recruitment and retention, encourage a team based approach to care, and improve access to services, patient satisfaction and value for money. There are currently three models under which Clinical Alternative Relationship Plans provide compensation to physicians: Sessional, Annualized and Capitation. There is ongoing development of funding models for Clinical Alternative Relationship Plans for the future. In 2011 – 2012 there were nine academic ARPs in Alberta, involving 10 academic programs with approximately 780 academic physicians as of March 31, 2012. This is an increase of 30 participating academic physicians since March 31, 2011. Participating physicians are primarily specialists and academic family physicians working in Edmonton and Calgary. Academic Alternate Relationship Plans are programs that pay academic physicians for activities that include: training physicians, performing clinical service, research and administration within the medical education and health systems.
- **Mental Health** — A new designation for mental health facilities was introduced in the province in accordance with the Mental Health Regulations. The new facility type will support new and emerging models of care. Three of these new facilities were designated in 2011 – 2012: Claresholm Centre Mental Health & Addictions, Southern Alberta Forensic Psychiatric Centre and Villa Caritas.
- **Optometrist Services** — Insured medical services provided by optometrists were expanded, as of April 2011, to include seniors and youth in addition to the adult population that had already been covered.
- **Physical Therapy Services** — The *Physical Therapists Profession Regulation* came into effect under the Health Professions Act on May 8, 2011. The regulation expands physical therapists' scope of practice by authorizing regulated members, with approved training, to order x-rays, magnetic resonance imaging, and ultrasound imaging.
- **Pharmacy Services** — The *Pharmacists and Pharmacy Technicians Profession Regulation* came into effect under the Health Professions Act on July 1, 2011. The regulation of pharmacy technicians allows them to more independently dispense prescription drugs, compound and sell prescription drugs, and compound blood products. Before a pharmacy technician can dispense or sell drugs directly to patients, a pharmacist must first evaluate the appropriateness of the prescription for the patient. Giving pharmacy technicians the authority to perform restricted activities will improve access to pharmacy services by allowing pharmacists to focus more on patient care through medication management, immunization, and patient counseling.

- **Physician Compensation** — A new Agreement in Principle for physician compensation, effective April 1, 2011 to March 31, 2013, was achieved with the Alberta Medical Association, and includes a 2.5 per cent increase for each of 2011 – 2012 and 2012 – 2013 along with an increase to Primary Care Networks per patient funding. It is an important step in building a strong working relationship between physicians and government by demonstrating consensus among all the parties on relationships, rates and processes. The Agreement in Principle is conditional on a formal agreement being finalized, approved and executed by June 30, 2012.

Expanded Role of Pharmacists

- The Transition Team (a representative group of pharmacists and pharmacy owners) met with government throughout 2011 – 2012 to discuss approaches to pharmacy services, including patient assessment by a pharmacist for renewal of prescriptions. Future implementation of expanded roles for pharmacists will build on the success of 2011 – 2012 influenza season in which pharmacists provided almost 90,000 Albertans with the influenza vaccine.

Improve and Reduce Wait Time

- The new Alberta Wait Time Reporting System was launched on the Ministry website in May, 2011. The website shows wait time information on surgical procedures and diagnostic tests, including MRI scans and cancer services as reported by Alberta specialists and facilities. The site allows Albertans to search wait times by procedure, by specialist and by facility, and indicates wait times trends over the most recent 13-month period.
- The number of hip and knee replacement surgeries, cataract surgeries, cancer surgery and other general surgeries were increased to reduce wait times.
- The emergency to home program was expanded province-wide in June 2011 to help seniors reduce avoidable emergency department visits by giving them supports to stay healthy in their homes and communities.
- The public was provided with access to estimated emergency department wait times in Calgary in July 2011 as the first phase of a provincial initiative to help people decide where to access care, with a goal to expand the service to other communities in the province.
- The care transformation program from the University of Alberta hospital was expanded to other Edmonton hospitals in August 2011 to improve access to acute-care services and reduce wait times in emergency departments.
- The newly expanded Stollery Children's Hospital pediatric emergency department was officially opened in January 2012 to provide Edmonton's first emergency department dedicated to pediatric and family-centred care. Fourteen beds were added to the neonatal intensive care unit at the Alberta Children's Hospital in Calgary in January 2012.

Access to Services Across the Continuum of Care

- Alberta's first Advanced Ambulatory Care Centre was opened in La Crete in June 2011 to improve access to primary care for local residents.
- A primary stroke centre was launched at the Northwest Health Centre in High Level in February 2012.
- The Minister accepted all 21 recommendations in the Health Quality Council of Alberta's review of health care issues on February 28, 2012.

Key Performance Measures and Results

Measure 3.A Access to primary care through Primary Care Networks

The Alberta Government is committed to further expanding and fine-tuning Primary Care Networks (PCNs), as well as the introduction of other ways of delivering primary care, to help ensure primary health care programs and services are available to all Albertans. This will continue to be a key strategy in improving quality, access and sustainability for the health system overall.

PCNs are a province-wide, comprehensive service delivery model to improve access to, and better coordinate, primary health care for Albertans. In a PCN, family physicians work with Alberta Health Services and other health professionals as a multi-disciplinary, integrated team to increase Albertans' access to the right care, from the right provider, at the right time.

As of October 2011, 2,216 physicians were registered with PCNs, and 2,553,384 Albertans received their primary health care through PCNs. PCNs have been successful in increasing Albertans' access to primary health care services and progressing toward 24/7 access to appropriate primary health care services.

According to research conducted by the Canadian Institute for Health Information (CIHI), access to a broad spectrum of services, including health promotion and disease prevention (offered by PCNs), as well as comprehensive, multi-disciplinary and coordinated care are markers of health care service delivery excellence.

Given that most family practices accept a limited number of new patients, the increase in the number of Albertans enrolled within a PCN is directly related to the registration of individual physicians with existing PCNs and the establishment of new PCNs. Also affecting the per cent of Albertans enrolled within a PCN are changes in the total population of Alberta registered with the Alberta Health Care Insurance Plan.

In 2010 – 2011, an additional 184 physicians registered with existing PCNs. This resulted in an additional 206,254 enrolled Albertans. Also in 2010 – 2011, 7 new PCNs were established, including the Athabasca PCN, the Cold Lake PCN, the Vegreville PCN, the Wetaskiwin PCN, the Vermillion PCN, the Grande Prairie PCN, and the Lloydminster PCN. This resulted in addition of 105 new physicians and an additional 125,063 enrolled Albertans.

The 2010 – 2011 result of 67 per cent is an increase of 7 per cent from the 2009 – 2010 result of 60 per cent. While the 2011 – 2012 target established in the *Health and Wellness Business Plan 2011 – 2014* of 68 per cent was not met, the 2010 – 2011 result of 67 per cent is very close to this target.

Access to primary care through Primary Care Networks

	2008/ 2009	**2009/ 2010**	**2010/ 2011**	**2011/ 2012**	**Target 2010/2011**
Percentage of Albertans enrolled in a Primary Care Network	55%	60%	67%	–	**68%**

Source: Health and Wellness. Claims Assessment System (CLASS) (numerator); Alberta Health Care Insurance Plan (AHCIP) population registration data (denominator).

Note: Result for 2011 – 2012 was not available because the source for denominator, 2011 – 2012 AHCIP Statistical Supplement, was not available as of June 30, 2012.

GOAL 4: Linked to Core Business – Leadership and governance

Excellence in health care

Albertans expect their health system to be capable of providing health services when they are needed while meeting or exceeding recognized standards of quality and safety. The Ministry establishes requirements for assurance to monitor compliance with accepted standards and performance targets. The ministry promotes a culture of excellence which emphasizes patient centered care, measurement, innovation and optimizing the use of research and technology, to support programs and mechanisms that maximize capacity and improve health care in Alberta.

Achievements

Information Technology

- **Electronic Health Record (EHR)** — Additional data continues to be added to EHR to provide a more comprehensive view of a patient's health status, making it an even more valuable tool for clinicians:
  - Inclusion of Canadian Blood Services' lab test results, including Perinatal Serology and Cross matching data;
  - Pacemaker reports from Grey Nuns, Misericordia and Sturgeon Hospitals;
  - Event reports from Alberta Cancer Care;
  - Screening Tests and Mammography results, Radiology Reports on Breast Cancer patients; and
  - Expanded collection of Radiology consult reports.
- **Alberta Netcare Portal** — The Provincial Image Viewer went live with implementation and integration into the Alberta Netcare Portal on August 25, 2011. The image viewer can access diagnostic images and reports contained in provincial repositories, providing a longitudinal patient view to clinicians. During the week days (Monday – Friday), the Netcare viewer is accessed by 1200 – 1300 distinct users; these users together launch the viewer approximately 3500 times a day.

Health Technology to Support Evidence-based Decision-making

- Fourteen health technology assessments were completed in 2011 – 2012.
- Assessment of new and existing health technologies continues to ensure that the introduction or funding of these services is based on sound clinical evidence.
- In 2011 – 2012, work continued to enhance the Alberta Health Technologies Decision Process by developing three key areas of the process: technology reassessment, access with evidence development and post-policy implementation review.

Alberta's *Continuing Care Strategy*

- The department has worked on the following initiatives to reduce continuing care wait times through the implementation of the Continuing Care Strategy and expanding home care options and community capacity for supportive living:
- In 2011 – 2012, the province, through Alberta Health Services, provided continuing care services through innovative service delivery models. This includes standardizing home care and supportive living services, enhancing respite care services, and supporting emergency department programs to support seniors to return to the community with enhanced home care services.
- In partnership with Alberta Health Services, government increased the available continuing care capacity in the province by 1,002 spaces to address the needs of an aging population. These spaces support the Government of Alberta's *Continuing Care Strategy: Aging in the Right Place* and span the spectrum of continuing care settings, including supportive living and long-term care spaces.

- The department concluded the 'Neighbours Helping Neighbours' initiative in March 2012, which was located in Edmonton and Jasper and partnered volunteers with seniors or those with disabilities to help them with everyday tasks and keep them connected with their communities. A formal and comprehensive evaluation of the project has been completed, and Health and Wellness is studying the results to determine potential stakeholder partnerships and next steps.
- The Caregiver Support and Enhanced Respite Pilot Project was conducted in Edmonton. This project involved a comprehensive assessment of the caregivers of individuals living in the community, with supports and interventions being provided based on the needs of both the individuals and their caregivers, including the flexible provision of respite care services. Alberta Health Services is now working to expand this initiative provincially.
- A pilot project in Grande Prairie and Medicine Hat was completed to evaluate assistive technologies that are designed to increase safety for seniors who live alone in their homes. These technologies are an integral component in the delivery of continuing care home care services.
- A strategic policy document was developed entitled *Home Care Redesign Strategic Plan: Shaping the Future 2012 – 2015.* This document presents a comprehensive 3 year plan to address provincial variation in Home Care Service Guidelines, the integration of home care with community and primary care supports and the types of services provided within the Home Care program.
- The department continues to revise the Continuing Care Health Service Standards to ensure that the continuing care system is flexible and responsive to the changing needs and expectations of its clients, to new models of care and to emerging best practices.

Product Listing Agreement Policy

- Product Listing Agreements (PLAs) are a mechanism by which therapies that may have otherwise not made it onto the provincial drug formulary (due to a high price or clinical uncertainty) can be listed and provide therapeutic choice to Government-sponsored drug plan beneficiaries. PLAs are confidential contracts in which a drug manufacturer agrees to supply a drug at a confidential discounted price and/or provide research investment in the province. This has various benefits which include increased access to new therapies, greater budget certainty/lower expenditures and investment in research within Alberta.

  At the end of March 2012, 10 successful agreements have been negotiated to provide Government sponsored Drug Plan members access to therapies previously not covered by the Drug Benefit List. In addition, Pan-Canadian agreements for two drugs have been established.

Provincial Framework for Emergency Medical Services

- In March 2012, Alberta Health Services signed contracts for the provision of emergency medical services (EMS) with the for-profit EMS operators. The contract is valid for a 5-year term with the possibility of extension. This ensures the stable, consistent provision of EMS in these communities and allows for-profit operators to perform long-term service planning which will improve patient care.
- AHS and Air Ambulance operators came to an agreement for a 2-year contract extension in February 2012. This extension ensures uninterrupted service of emergency fixed-wing air ambulance, which completes an average of 6,000 medevacs per year.
- At the request of municipalities, consolidation of emergency medical services dispatch occurred in the City of Edmonton, Parkland County, Leduc County, Camrose, Flagstaff, Bashaw and Hanna. Consolidation has provided immediate service as required, as in the case of the two RCMP Mounties who were shot on February 7, 2012. An Edmonton-based ambulance, on its return to Edmonton from completing a patient transfer, was quickly and effectively dispatched to Killam hospital to carry out a transport call for these two injured Mounties. Consolidation ensures that the closest ambulance to a call's location is dispatched.

- Collaboration between a rural 911 centre, Health and Wellness and Alberta Health Services has resulted in the creation of an emergency medical services dispatch protocol used to locate "hard-to-find" rural addresses and cell phone caller locations. Use of this protocol has reduced the amount of time it takes for ambulances to arrive on scene in rural areas and to respond to cell phone users.
- In February 2012, AHS began online reporting of EMS response times for the Edmonton and Calgary areas. This reporting has allowed residents to access information on EMS system performance in those areas. Roll-out of online reporting in other areas is scheduled for the near future.
- The Community Health and Pre-Hospital Support Program (CHAPS) was rolled out across the province after successful completion of the pilot project in Edmonton. Paramedics are now able to refer patients to Home Care and other community services resulting in patients being able to remain safely in their homes. This initiative reduces a patient's dependence on 911 and the need of EMS transport to emergency departments. As a result, more EMS crews will be available to respond to the next emergency call.
- On September 24, 2011, EMS was awarded a grant of armorial bearing consisting of a heraldic badge and flag on behalf of Queen Elizabeth II and the Government of Canada. EMS is one of three EMS organizations in Canada, the other two being City of Toronto and Services D'Urgences Quebec, to be awarded a coat of arms to signify the vital role EMS plays in health care and their service to Canadians.
- Alberta Health Services has integrated the emergency medical services (EMS) crews into several rural health clinics, such as the one in Rainbow Lake, in order to fully utilize EMS practitioners' skills sets in the broader community. As well, this initiative contributes to the provision of EMS in rural and remote locations, which typically have low call volumes. As such, EMS practitioners are more likely to remain in communities in which their skill sets will be fully utilized in providing quality medical service.

Key Performance Measures and Results

MEASURE 4.A Patient safety

Albertans deserve a safe health care system that they can rely on whenever and wherever they receive health services. This measures Albertans perception of receiving and reporting harm while receiving health services.

The Health Quality Council of Alberta (HQCA) 2012 survey of Albertans age 18 and older found that 11 per cent of Albertans reported unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year. Statistically, this is not a significant difference compared to 12 per cent in 2010 – 2011.

This past year has had an unprecedented number of inquiries and news releases regarding health system quality and patient safety.

The HQCA was asked to review multiple matters respecting patient safety and health service quality:

- *Emergency medical services (EMS) response times and emergency department (ED) wait times* (currently underway, to be completed October, 2012);
- *Quality of care and safety of patients requiring access to emergency department care and cancer surgery and the role of physician advocacy* (final report February, 2012); and
- *Safety implications for patients requiring medevac services to and from the Edmonton international airport* (final report May, 2011).

These reviews have created greater awareness and attention about potential concerns in Alberta's health system and will provide input into improving safety in health care. Though it may be impossible to eliminate unexpected harm entirely, it is feasible to continually learn and improve systems and processes to minimize it.

Alberta Health Services (AHS) fully deployed its reporting and learning system for patient safety in March 2011. AHS had been using the system to track, investigate and learn from adverse events. Included in this deployment is the policy to govern disclosure of adverse events to patients.

Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year

	2005/ 2006	**2007/ 2008**	**2009/ 2010**	**2010/ 2011**	**2011/ 2012**	**Target 2011/2012**
Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year	13%	10%	9%	12%	11%	**9%**

Source: Health Quality Council of Alberta. Satisfaction and Experience with Health Care Services: A Survey of Albertans (2006, 2008, 2010, 2012). Health Quality Council of Alberta. Provincial Survey about Health and the Health System in Alberta (2011).

MEASURE 4.B Continuing care: Number of persons waiting in an acute care hospital bed or waiting in the community for continuing care placement

The number of persons waiting in an acute care hospital bed indicates the number of acute/sub-acute care beds that are being occupied by patients who no longer require acute/sub-acute care. The number of persons waiting in the community for continuing care indicates how many people are waiting in the community for continuing care spaces. As well, these numbers indicate unmet demand for continuing care spaces including those in long-term care facilities such as nursing homes and auxiliary hospitals or designated supportive living environments such as Supportive Living Level 3, Supportive Living Level 4, and Supportive Living Level 4 Dementia.

Continuing care clients are not defined by age, clinical diagnosis or the length of time they may require service, but by their need for continuing care.

Continuing care differs from acute/sub-acute care, as services are usually ongoing rather than episodic in nature and needs are beyond what could be addressed through primary care alone.

In 2011 – 2012, the target of 375 individuals waiting for continuing care admission while in an acute/sub-acute care facility was not met. Although the number of individuals waiting in acute/sub-acute care for a continuing care living option remained fairly constant, 471 individuals for 2010 – 2011 and 467 individuals for 2011 – 2012, the average time that individuals waited decreased by 24 per cent, going from 54 days to 41 days. In addition, the proportion of individuals (regardless of where they waited — acute/sub-acute care or in the community) who were admitted to a continuing care option within 30 days of being assessed as requiring continuing care increased from 55 per cent in 2010 – 2011 to 64 per cent in 2011 – 2012. There has also been an increase in the total number of individuals being admitted to a continuing care living option from 4,951 in 2010 – 2011 to 5,337 in 2011 – 2012, an increase of about 8 per cent.

In 2011 – 2012, the target of 900 individuals waiting for continuing care admission while in the community was not met. Although the actual number of people waiting in the community has remained fairly stable over the past four years, there has been a shift in wait location. Between 2008 – 2009 and 2011 – 2012, the proportion of individuals admitted from the community and waiting in the community has increased as a result of policy aimed at reducing acute care occupancy rates. Additionally, review of the current waitlist indicates that those waiting in the community include both those waiting urgently for the first available space, and those waiting until their first choice of location becomes available. The latter group include individuals waiting who may have been on the waitlist for an extended period of time; they are being managed in the community and are able to wait until a space becomes available in their facility of choice.

Continuing care

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	Target 2011/2012
Number of persons waiting in an acute care hospital bed for continuing care	645	754	707	471	467	**375**
Number of persons waiting in the community for continuing care	___	1,065	1,039	1,110	1,002	**900**

Source: Alberta Health Services. Stratahealth Pathways (Calgary and Edmonton Zones); Meditech (North, Central and South Zones)

Measure 4.C Wait time for hip replacement surgery

Measure 4.D Wait time for knee replacement surgery

Hip replacement surgery is the second most common joint replacement surgery in Alberta specifically and North America in general. Providing reasonable and timely access to hip replacements is a major objective and a defining attribute of the publicly funded health system in Alberta. Longer waits for necessary hip replacements affect health status and quality of life and result in more costly health services.

In 2011 – 2012, 90 per cent of patients received hip replacement surgery within 40 weeks from the decision to treat. The wait time increased from the previous year, and was significantly longer than the national benchmark of 26 weeks. Currently, 80 per cent of Alberta patients receive their hip replacement surgery within 26 weeks.

Knee replacement surgery is the most common joint replacement surgery in Alberta specifically and North America in general. Typically the procedure is undertaken for patients with a condition of osteoarthritis and occurs with greatest frequency in those aged 60 and older. In Alberta, 80 per cent of the patients undergoing elective surgery for knee replacement since 2003 have been over 60 years of age. Given the rapidly aging population in the province, the incidence and importance of this procedure can be expected to increase markedly over the foreseeable future.

In 2011 – 2012, 90 per cent of patients received knee replacement surgery within 48 weeks from the decision to treat. The wait time is virtually the same result as achieved in the previous year and is significantly longer than the national benchmark of 26 weeks. Currently, 70 per cent of Alberta patients receive knee replacement surgery within 26 weeks.

Alberta Health Services has undertaken a number of actions in 2011 – 2012 to improve access to hip and knee replacement surgery, including:

- Establishing a provincial plan for hip and knee replacements to look at backlog and identify areas for increased volume;
- Performing an additional 1,000 hip and knee replacement surgeries;
- Implementing a focused approach to clearing up existing wait lists in an effort to ensure that the existing waitlists are accurate and patients are receiving the appropriate care;
- Establishing multidisciplinary teams to work on efforts to reduce the length of stay of hip and knee replacement patients to the proposed benchmarks.

Wait times for hip replacement and knee replacement surgery: 90th percentile wait time in weeks

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	Target 2011/2012
Hip replacement surgery	36	36	35	39	40	**27 weeks**
Knee replacement surgery	49	46	49	49	48	**35 weeks**

Source: Alberta Health Services. Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, Alberta Waitlist Registry, and manual data collection).

MEASURE 4.E Wait time for cataract surgery

One of the leading causes of visual impairment in North America is cataracts. Cataracts have been identified in about 50 per cent of persons between 65 and 74 years of age, and in about 70 per cent of those over the age of 75 years. Surgical removal of the lens, the only currently available treatment for cataract-associated vision loss, is capable of restoring visual function in 90 per cent of cases. Cataract surgery is the most common surgery in Alberta and one of the major concerns for timely treatment of residents of the province.

In 2011 – 2012, 90 per cent of patients received scheduled cataract surgery (first eye) within 35 weeks from the decision to treat. The wait time decreased substantially from the previous year, but was still significantly longer than the national benchmark of 16 weeks for high risk patients. These results do not differentiate high risk patients from those deemed not to be high risk.

Alberta Health Services has undertaken a number of actions in 2011 – 2012 to improve access to cataract surgery, including:

- Increasing the number of cataract surgeries provincially by over 2,000;
- Implementing a focused approach to clearing up existing wait lists in an effort to ensure that the existing wait lists are accurate and patients are receiving the appropriate care.

Wait time for cataract surgery: 90th percentile wait time in weeks

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	Target 2011/2012
Cataract surgery	28	30	42	47	35	**30 weeks**

Source: Health and Wellness. Alberta Wait Times Reporting, Business Intelligence Environment (BIE).

MEASURE 4.F Alberta Netcare: Number of care providers accessing Alberta Netcare

Alberta Netcare (Alberta's electronic health record – EHR) is a clinical information network that links community physicians, pharmacists, hospitals, and other authorized health care professionals across the province. Netcare lets health care practitioners view health information such as patient allergies, prescriptions and lab tests electronically. As more health providers access the system, more consistent and improved treatment decisions will result.

Alberta Netcare: Number of care providers accessing Alberta Netcare

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	Target 2011/2012
Number of care providers accessing Alberta Netcare	29,110	34,200	39,866	–	–	**45,229**

Source: Health and Wellness, Health Information Technology and Systems Division, Electronic Health Record applications (2007/2008; 2008/2009; 2009/2010).

Note: During 2010 – 2011 and 2011 – 2012, some older systems that were a source for reporting this measure were retired and the surviving systems are now feeding a new reporting system. The methodology to gather and report the counts under the new system, as provided by Alberta Health Services, is still in progress for validation. Data available for 2010 – 2011 and 2011 – 2012 are not reliable and are not comparable to prior years. Therefore, results for 2010 – 2011 and 2011 – 2012 are not reported in the 2011 – 2012 annual report.

MEASURE 4.G Physician utilization of electronic medical records

This performance measure quantifies the adoption rate of electronic medical record (EMR) technology into physician practices. EMR technology supports best practice care delivery and helps community physicians provide improved primary care services to Albertans.

EMR adoption is supported through the EMR Completion Program, which superseded the Physician Office System Program (POSP) on April 1, 2011. The role of the program is to enable the use of electronic medical records by physicians, who provide insured services in Alberta, to improve patient care and support best practice care delivery within Alberta's electronic health environment.

The EMR Completion Program is still referred to as POSP to avoid brand confusion. It provides financial and change management support to community physicians who want to implement an EMR system in their clinic. The goal of the program is to finish deploying EMR solutions to all Alberta community physicians by March 31, 2014.

The EMR Completion Program is governed by an interim advisory committee with representatives from Health and Wellness, the Alberta Medical Association and Alberta Health Services. POSP is an integral component of Alberta Netcare, the province's electronic health record strategy.

During the 2011 – 2012 fiscal year, a total of 541 physicians implemented an EMR under the program. To date, 2,366 physicians out of an eligible 4,820 (57 per cent) have implemented an EMR. This is below the target of 60 per cent adoption.

Physician utilization of electronic medical records

	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	Target 2011/2012
Physician utilization of electronic medical records: Percentage of community physicians using the Electronic Medical Record in their clinic	45%	46%	46%	53%	57%	**60%**

Sources: Alberta Medical Association (AMA) membership database (MSIS); POSP funding and enrolment database (iPOSP); Alberta Health Services (AHS) lab destinations per physician.

MEASURE 4.H Generic drug spending in Alberta

Generic drugs are significantly less expensive than the Brand equivalents. The Government continues to implement changes to reduce the costs of prescription drugs for all Albertans. Initiatives like limiting the price of generics provide a direct cost reduction.

The per cent of generic prescription drugs dispensed in community pharmacies is an indicator of the affordability of prescription drugs for Albertans. Essentially, prescription drugs become more affordable as a larger share of Albertans' drug purchases are generic drugs.

The 2011 – 2012 target for generic drug spending in Alberta was met and exceeded by 3.1 per cent. Key brand drugs have become generic, including Lipitor, Pantaloc, Adalat, Zyprexa and Diovan, supporting the upward trend in the community dispensed percentage of generic prescription drugs in Alberta.

Generic drug spending in Alberta

	2007	**2008**	**2009**	**2010**	**2011**	**Target 2011/2012**
Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta	29.3%	32.8%	35.1%	38.8%	41.9%	**38%**

Source: IMS Brogan, Canadian Compuscript; Health and Wellness, Pharmaceutical Funding and Guidance Branch.

Changes to Performance Measures Information

New or Changed Performance Measures in the 2011 – 2012 Annual Report:

- None

Key Performance Measures discontinued in the 2012 – 2015 Business Plan:

- Alberta Netcare: Number of care providers accessing Alberta Netcare

New or Changed Performance Measures in the 2012 – 2013 Annual Report:

Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)

- Chlamydia
- Gonorrhea
- Syphilis

Congenital syphilis: Rate per 100,000 births (live and still born)

Performance Measures – Data Sources and Methodology

Data Sources

1.a. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2006, 2008, 2010, 2012). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

2 a. Statistics Canada. Canadian Community Health Survey (CCHS), Alberta Share File, 2005, 2007, 2008, 2009, 2010.

2.b. Alberta Health Services Zones, Community Partners, First Nations and Inuit Health, Health Canada (Alberta Region), Health and Wellness' Interactive Health Data Application.

2.c. Health and Wellness. CDRS-STI (Communicable Disease Reporting System — Sexually Transmitted Infection).

3.a. Health and Wellness. Claims Assessment System (CLASS) (numerator); Alberta Health Care Insurance Plan (AHCIP) population registration data (denominator) as of March 31, 2011.

4.a. Health Quality Council of Alberta. *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2006, 2008, 2010, 2012). Health Quality Council of Alberta. *Provincial Survey about Health and the Health System in Alberta* (2011).

4.b. Alberta Health Services. Stratahealth Pathways (Calgary and Edmonton Zones); Meditech (North, Central and South Zones).

4.c. Alberta Health Services. Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, Alberta Waitlist Registry, and manual data collection).

4.d. Alberta Health Services. Multiple Operating Room Systems across Alberta (PICIS, Meditech, VAX, Alberta Waitlist Registry, and manual data collection).

4.e. Health and Wellness. Alberta Wait Times Reporting, Business Intelligence Environment.

4.f. Health and Wellness, Health Information and Technology Systems Division, Electronic Health Record (EHR) applications (2007/2008; 2008/2009; 2009/2010).

4.g. Alberta Medical Association (AMA) membership database (MSIS); Physician Office System Program (POSP) funding and enrolment database (iPOSP); Alberta Health Services (AHS) lab destinations per physician.

4.h. IMS Brogan, Canadian Compuscript; Health and Wellness, Pharmaceutical Funding and Guidance Branch.

Methodology

1.a Satisfaction with health care services received: Percentage of Albertans satisfied or very satisfied with health care services personally received in Alberta within the past year

The result for this measure is based on the Health Quality Council of Alberta *Satisfaction and Experience with Health Care Services: A Survey of Albertans* (2012). This measure is defined as the total percentage of respondents who responded "satisfied" or "very satisfied" to the question:

"Thinking about all of your personal experiences within the past year with the health care services in Alberta that we just reviewed, to what degree are you satisfied or dissatisfied with the services you have received? Please use a scale of 1 to 5 where '1' means 'very dissatisfied' and '5' means 'very satisfied'."

In 2012, data were collected through a telephone survey of 2,658 randomly selected Alberta households. The overall response rate for the survey was 32.8 per cent. A total of 2,484 respondents answered the question on satisfaction with health care services personally received in Alberta within the past year. Results are reliable within ±2.6 per cent, 19 times out of 20.

2.a Smoking: Prevalence of smoking

- **Alberta youth aged 12 to 19 years**
- **Young adults aged 20 to 24 years**

This measure is defined as the percentage of Alberta youth 12 to 19 years, and young adults 20 to 24 years, who report that they smoke daily or occasionally.

The Canadian Community Health Survey (CCHS) includes a wide range of questions about the health and health behaviours of residents in each province; since 2007, it is conducted annually. The CCHS includes questions about the respondent's smoking habits. If respondents answer "yes" to the question, "In your lifetime, have you smoked a total of 100 or more cigarettes (about 4 packs), then respondents are then asked the question: "At the present time, do you smoke cigarettes daily, occasionally or not at all?"

Responses to this question, analyzed by the age group of the respondent, provide the results reported on the current prevalence of smoking among these age groups.

In 2010, the result on the prevalence of smoking among Alberta youth aged 12 to 19 years is reliable within ± 1.7 per cent, 19 times out of 20. Among young adults aged 20 to 24 years, the result on the prevalence of smoking is reliable within ± 3.3 per cent, 19 times out of 20.

2.b Influenza immunization: Percentage of Albertans who have received the recommended seasonal influenza immunization

- **Seniors aged 65 and over**
- **Children aged 6 to 23 months**
- **Residents of long term care facilities**

Numerator data was manually collected in each zone on the seasonal influenza NCR data collection form. Information was aggregated by each zone and sent centrally for inclusion into the provincial report. Numerators represent immunizations delivered by Alberta Health Services, Community Providers and First Nations. denominator data was retrieved from the Alberta Health Interactive Health Data Application which is based on mid-year (June 30) registration population estimates. First Nations communities are also included in the denominator. Alberta residents living in Lloydminster are not included in either the numerator or denominator.

Seniors' immunization rate includes all persons 65 years and older in Alberta who have received one dose of influenza vaccine in the 2011 – 2012 season. Rates for children aged 6 to 23 months of age in 2009 – 2010, 2010 – 2011 and 2011 – 2012 are calculated as "dose 2 of 2 + Annual". Prior to 2009 – 2010 this rate was calculated as "Doses 1 of 1 + Annual". In order to meet the timelines for the Health and Wellness Annual Report, results for seniors and children aged 6 to 23 months are current as of March 31, 2012, which is earlier than the end of the seasonal influenza immunization season.

The rate for Long Term Care (LTC) residents are representative of a snapshot immunization rate in the Long Term Care population on December 15th, 2011. It is necessary to define the immunization rate in this way due to the high turnover in this population. Using the total number of Long Term Care residents immunized in 2011 – 2012 instead of a snapshot may result in a coverage rate of over 100 per cent.

2.c Sexually transmitted infections: Rate of newly reported infections (per 100,000 population)

- **Chlamydia**
- **Gonorrhea**
- **Syphilis**

Results for this measure are based on data from Health and Wellness' Communicable Disease Reporting System — Sexually Transmitted Infection (CDRS-STI) database, which provides the number of newly reported cases of sexually transmitted infection, by type of infection, in a given calendar year, and the Health and Wellness' Interactive Health Data Application, which provides the mid-year population in a given calendar year.

Calculation of Sexually Transmitted Infection Rate
Sexually transmitted infection rate = (Number of newly reported cases in given calendar year/ Mid-year population of given calendar year) × 100,000

3.a Access to primary care through Primary Care Networks: Percentage of Albertans enrolled in a Primary Care Network

The result of this measure is based on the number of patients enrolled in a Primary Care Network (PCN) as a proportion of the total population covered under the AHCIP as of March 31 in a given fiscal year. Patients are considered to be enrolled in a PCN when they are assigned to a physician/nurse practitioner/pediatrician registered to a PCN. There are 4 steps used to assign a patient to a physician:

Step 1: Patients who have seen one physician/nurse practitioner/pediatrician only are assigned to that physician/nurse practitioner.

Step 2: Patients who have seen more than one physician, but one physician is predominant, and then assigns the patient to that physician.

Step 3: Patients who have seen multiple physicians the same number of times are assigned to the physician who did the physical exam last.

Step 4: Patients who have seen multiple physicians the same number of times and had no physical examination done are assigned to the physician who saw the patient last.

These 4 steps are part of the four-cut methodology.

The number of patients linked to a PCN is calculated by the payments issued to the program, which is associated with the providers within the PCN. The payments to the PCN are identified by the payments the providers receive through the Claims Assessment System (CLASS). CLASS is an application that collects process claims transactions for physicians of multiple disciplines for fee-for-service items. A schedule of medical benefits is associated with each medical discipline and provides information on compensation for physician services. The calculation of the percentage of Albertans enrolled in a PCN is based on the number of enrollees (numerator) divided by the number of the total population covered in the province (denominator). The denominator is the number of Albertans registered with a Personal Health Number (PHN). The 2010 – 2011 number of Albertans registered with a PHN was used to calculate the 2010 – 2011 result, based on the Alberta Health Care Insurance Plan Statistical Supplement 2010 – 2011.

4.a Patient safety: Percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year

The result for this measure is based on the Health Quality Council of Alberta *Satisfaction and Experience with Health Care Services: A Survey of Albertans (2012)*. This measure is defined as the percentage of survey respondents who answered "yes" to the question:

"To the best of your knowledge, have you, or has a member of your immediate family experienced UNEXPECTED HARM while receiving healthcare in Alberta WITHIN THE PAST YEAR?"

In 2012, data were collected through a telephone survey of 2,658 randomly selected Alberta households. The overall response rate for the survey was 32.8 per cent. A total of 2,386 respondents answered the question on patient safety, as indicated by the percentage of Albertans reporting unexpected harm to self or an immediate family member while receiving health care in Alberta within the past year. Results are reliable within ±1.7 per cent,19 times out of 20.

4.b Continuing care:

- **Number of persons waiting in an acute care hospital bed for continuing care**
- **Number of persons waiting in the community for continuing care**

The result for this measure is based on submissions from representatives from each of the five geographic Alberta Health Services (AHS) Zones. These AHS Zones are responsible for submitting the number of persons waiting in an acute care hospital bed for continuing care placement to AHS Health System Compliance and Accountability on a monthly basis. This information is submitted to Health and Wellness on a quarterly and annual basis.

For the number of persons waiting in an acute care hospital bed for continuing care, the result is calculated as the arithmetic sum of persons waiting in all acute care facilities for continuing care placement in the five geographic AHS zones as of March 31st in a given fiscal year.

For the number of persons waiting in the community for continuing care, the result is calculated as the arithmetic sum of persons waiting in the community for continuing care placement in the five geographic AHS zones as of March 31st in a given fiscal year.

4.c Wait time for hip replacement surgery: 90th percentile wait time in weeks

The result for this measure is based on the time (in weeks) within which 90 per cent of person cases were completed (had their procedure performed as planned). The calculation uses Alberta Health Services (AHS) records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:

Wait time = completion date – decision to treat date

for each AHS record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

4.d Wait time for knee replacement surgery: 90th percentile wait time in weeks

The result for this measure is based on the time (in weeks) within which 90 per cent of person cases were completed (had their procedure performed as planned). The calculation uses Alberta Health Services (AHS) records of persons served from April 1 to March 31 of the reporting fiscal year. It does not include persons who voluntarily delayed their procedure, or those who had a scheduled follow-up procedure, or those that received emergency surgical care.

The general definition of a percentile is a point on a rank-ordered scale, found by sorting a group of observations* in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. For example, a wait time equal to or greater than 90 per cent of other observations is the 90th percentile wait time.

*Each observation is the wait time, computed as:

Wait time = completion date – decision to treat date

for each AHS record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period.

4.e Wait time for cataract surgery: 90th percentile wait time in weeks

This wait time for cataract surgery is the 90th percentile wait time (in weeks) from the decision to treat date to the treatment date (first eye). The calculation uses Alberta Health Services (AHS) records of persons served from April 1 to March 31 of the reporting fiscal year. When cataract surgery is required for a patient's both eyes, only the wait time for surgery on the first eye is included in the wait time calculations.

A percentile is defined as a point on a rank-ordered scale, found by sorting a group of observations in order of magnitude from lowest to highest. The first percentile approximates the very lowest/bottom number found, while the 100th percentile is the very highest reported. The nth percentile is the point exceeding n per cent of the observations. The 90th percentile wait time is the observed wait time that is equal to or greater than 90 per cent of other observations.

*Each observation is the wait time, computed as:

Weeks wait = (treatment date – decision to treat date)/7

for each AHS record meeting specified inclusion/exclusion criteria, completed on or 365 days prior to the last day of the reporting period for each wait listed cataract surgery case recorded in the Alberta Wait Times Reporting (AWTR) meeting specified inclusion/exclusion criteria. For the ministry 2011 – 2012 Annual Report, data were obtained from the AWTR on May 23, 2012, and the result was calculated using the fiscal year period of April 1, 2011 to March 31, 2012.

4.f Alberta Netcare: Number of care providers accessing Alberta Netcare

The methodology for reporting on the number Alberta Netcare users is under development by Health and Wellness and Alberta Health Services.

4.g Physician utilization of electronic medical records: Percentage of community physicians using the electronic medical record in their clinic

This performance measure quantifies the adoption rate of electronic medical record (EMR) technology in physician practices.

The number of community physicians enrolled in the Physician Office Support Program (POSP) that are using an EMR in their clinic is reported as a proportion of the total number of community physicians that are potentially eligible to be enrolled in POSP.

Calculation of Results:

1. Numerator:
   - a) The number of POSP grant-funded physicians that were using an EMR plus the total number of physicians who have implemented an EMR from a qualified vendor (achieved Milestone 3/Go-Live).
   - b) Note: POSP has changed from grant funding to invoice-based reimbursement. Going forward, the assumption has been that physicians who received grant funding will continue to use EMRs unless POSP is notified otherwise. This assumption is substantiated with periodic reviews by POSP.
2. Denominator:
   - a) An extract from the AMA database provides all members and staff positions. Staff, non-physicians and deceased members are removed based on AMA charge codes.
   - b) Physicians who do not have a work or home address in Alberta are removed. The address is contained in the data from the AMA database.
   - c) Non-community based physicians are removed based on:
     - i) Specialty: The specialties are identified as physicians who do not provide primary care to patients in a clinical setting as their point of care is in a hospital or research facility.
     - ii) Lab results: Physicians whose lab results are sent only to an AHS facility or military facility.
   - d) Physicians who have previously engaged with POSP and are known to be working in an academic facility are removed.
   - e) Final denominator value: 4,820 physicians.

4.h Generic drug spending in Alberta: Community dispensed percentage of generic prescription drugs in Alberta

This measure compares empirical data for retail (customer) expenditure of generic drugs versus brand name prescription drugs in Alberta.

The data source is IMS Brogan, Canadian CompuScript, as analyzed and reported by the Pharmaceutical Funding and Guidance Branch, Health and Wellness. *The Canadian CompuScript Audit* measures the number of prescriptions dispensed by Canadian retail pharmacies. Product information is presented according to therapeutic class, and for each product the following data elements are collected: manufacturer, form, strength, new vs. refill prescription, prescription size and price, transaction location, transaction date, MD number (if available), third-party payer (if available), and authorized repeats. The Compuscript data is collected monthly from a panel of more than 5,600 drug stores distributed proportionately within each of the strata, and across the various chain affiliates.

The Compuscript methodology changes in 2005 have no impact on the data. This is due to introduction of new CompuScript Next Generation (G2) in January 2008 with 3 years of restated back data (January 2005 forward) maintaining accurate trending.

For totals of generics and totals of brand manufactured drugs, the sampling error for Alberta is around +/-3 per cent to +/- 5 per cent for Total Brand and +/- 3 per cent to +/- 5 per cent for Total Generics. On an individual product basis, the vast majority of brand products (top 300) will have a sampling error of +/-10 per cent to +/- 15 per cent, and the majority of generic products (top 300) will have a sampling error of +/- 10 per cent to +/-15 per cent.

Calculation of Result: The result is calculated as the quotient of the numerator and denominator, defined as follows:

Numerator: The estimated value of generic manufactured prescription drugs dispensed from Alberta retail pharmacies (includes markups and professional fees).

Denominator: Is the total (generic and brand manufactured) estimated value of manufactured drugs dispensed from Alberta retail pharmacies (includes markups and professional fees).

Results are calculated using calendar year data.

Ministry Expense by Function

MINISTRY FINANCIAL HIGHLIGHTS

The Fiscal Plan document such as the Budget and quarterly forecasts report on a different basis than the audited Consolidated Ministry Financial Statements in the Annual Report. The Consolidated Ministry Financial Statements includes revenue, expense, assets and liabilities of Crown-controlled Schools, Universities, Colleges and Hospitals (SUCH) sector entities. For Health and Wellness, this includes Alberta Health Services, Health Quality Council of Alberta, Calgary Health Trust, and Alberta Cancer Foundation. This section will focus on the results on a fiscal plan basis.

The following tables reflect the same scope of reporting as Budget 2011 and the 2011 – 2012 quarterly fiscal updates and also includes the net impact of SUCH sector entities as a single line item.

REVENUES

Revenues

(in thousands)

	2012		
	Budget	Actual	2011 Actual
Internal Government Transfers	$ 25,000	$ 22,481	$ 18,750
Transfers from the Government of Canada	2,301,688	2,191,864	2,215,114
Premiums, Fees and Licences	57,609	56,202	58,035
Other Revenue	96,154	183,879	161,636
Total Revenue (Fiscal Plan Basis)	2,480,451	2,454,426	2,453,535
Alberta Health Services and Other Health Sector Entities	–	1,671,281	1,576,510
Total Revenue (Ministry Consolidated Financial Statement Basis)	$ 2,480,451	$ 4,125,707	$ 4,030,045

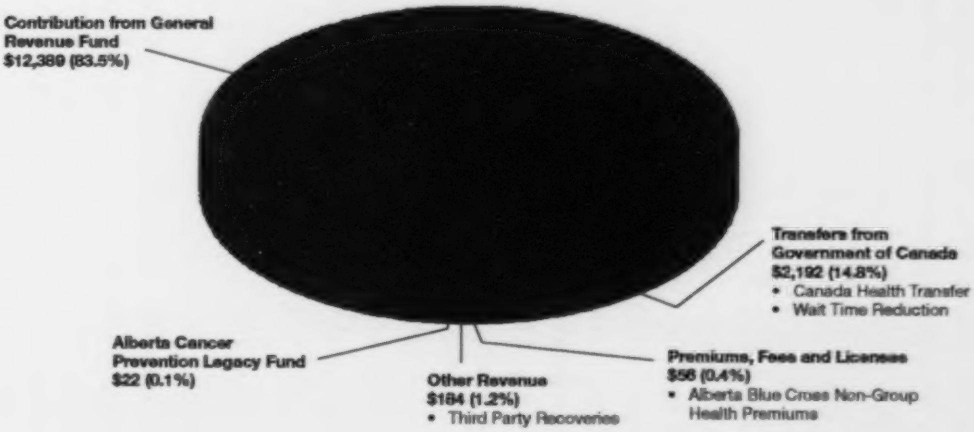
Details on the Ministry's revenues can be found in Schedules 1 and 3 of the Ministry's Consolidated Financial Statements.

Revenue increased by $0.9 million from fiscal 2010 – 2011. The change was primarily due to a $14.6 million increase from other revenue sources such as revenue from insurance companies to cover medical expenses for individuals claims and grants funding previous provided to the former regional health authorities(RHA) for any initiative that is no longer needed under Alberta Health Services (AHS). Additionally a $7.6 million increase from miscellaneous revenue sources such as Infoway Canada for investment in information technology initiatives, and a $3.7 million increase from the Alberta Cancer Prevention Legacy Fund. Partially offsetting this was a decrease of $23.2 million in the transfers from the Government of Canada and a decrease of $1.8 million due to Supplementary Health Benefits Premium.

Health and Wellness

2011 – 2012 Funding Sources

($ Millions)



Total — $14.8 Billion

EXPENSES

Expenses

(in thousands)

	2012		
	Budget	**Actual**	**2011 Actual**
Total Expense (Fiscal Plan Basis)	$ 14,947,320	$ 14,843,407	$ 14,736,573
Alberta Health Services and Other Health Sector Entities	–	1,358,732	377,602
Total Expense (Ministry Consolidated Financial Statement Basis)	$ 14,947,320	$ 16,202,139	$ 15,114,175

Details on the Ministry's expenses can be found in Schedule 2 of the Ministry's Consolidated Financial Statements.

Spending of $14.8 billion remained relatively constant in 2011 – 2012 with an increase of less than 1 per cent from 2010 – 2011.

$9.6 billion of the Health and Wellness budget was provided to AHS for operational support of the health system. As part of the government's five year funding commitment, a 6 per cent increase was provided in 2011 – 2012 to AHS' base operating funding.

Spending on Physician Compensation and Development was over $3.5 billion for items such as physician fee-for-services, physician office automation, and specialist on call services. The continued operation and expansion of Primary Care Networks, Alternate Relationship Plans, and residency training positions were also supported.

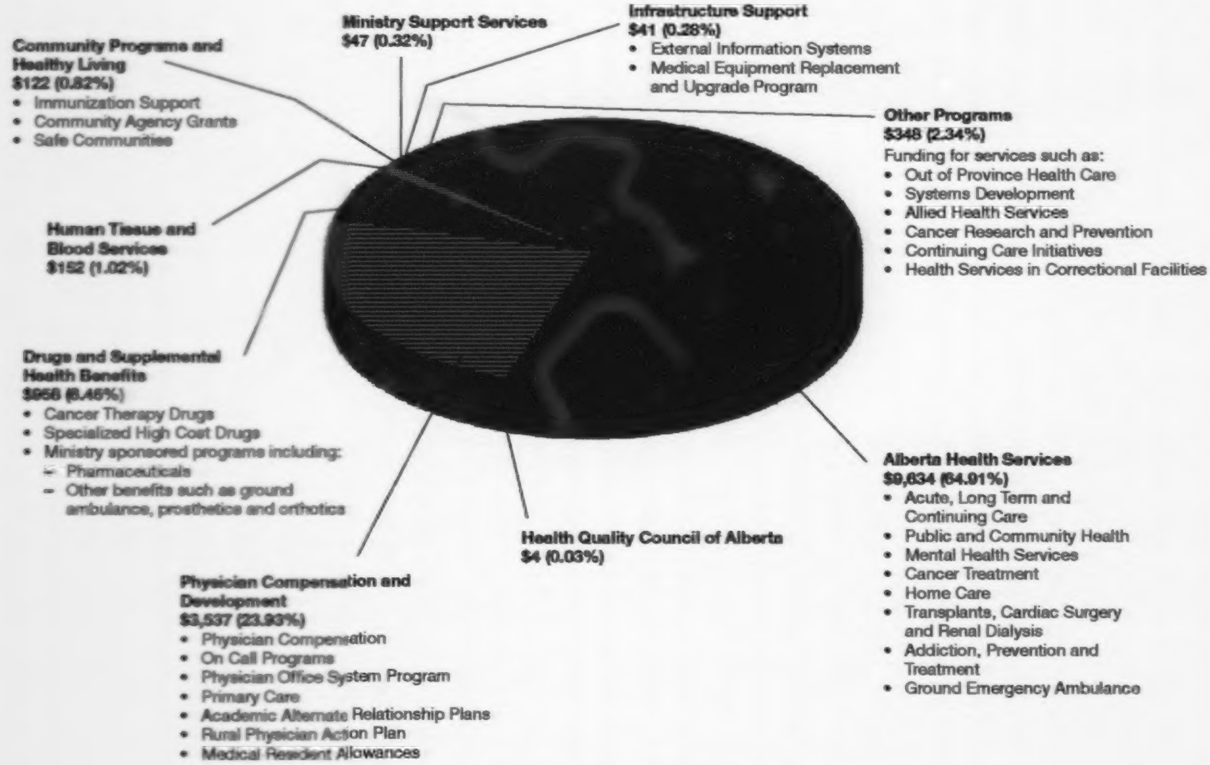
Costs are $958 million for prescription drugs, ambulance services and other health benefits for Albertans. Included in the $958 million is spending on items such as cancer therapy drugs and specialized high cost drugs.

$714 million supported allied health professionals such as oral surgeons, optometrists and podiatrists, vaccination programs, community health services, provision for blood and blood products, health services in correctional facilities, and infrastructure support.

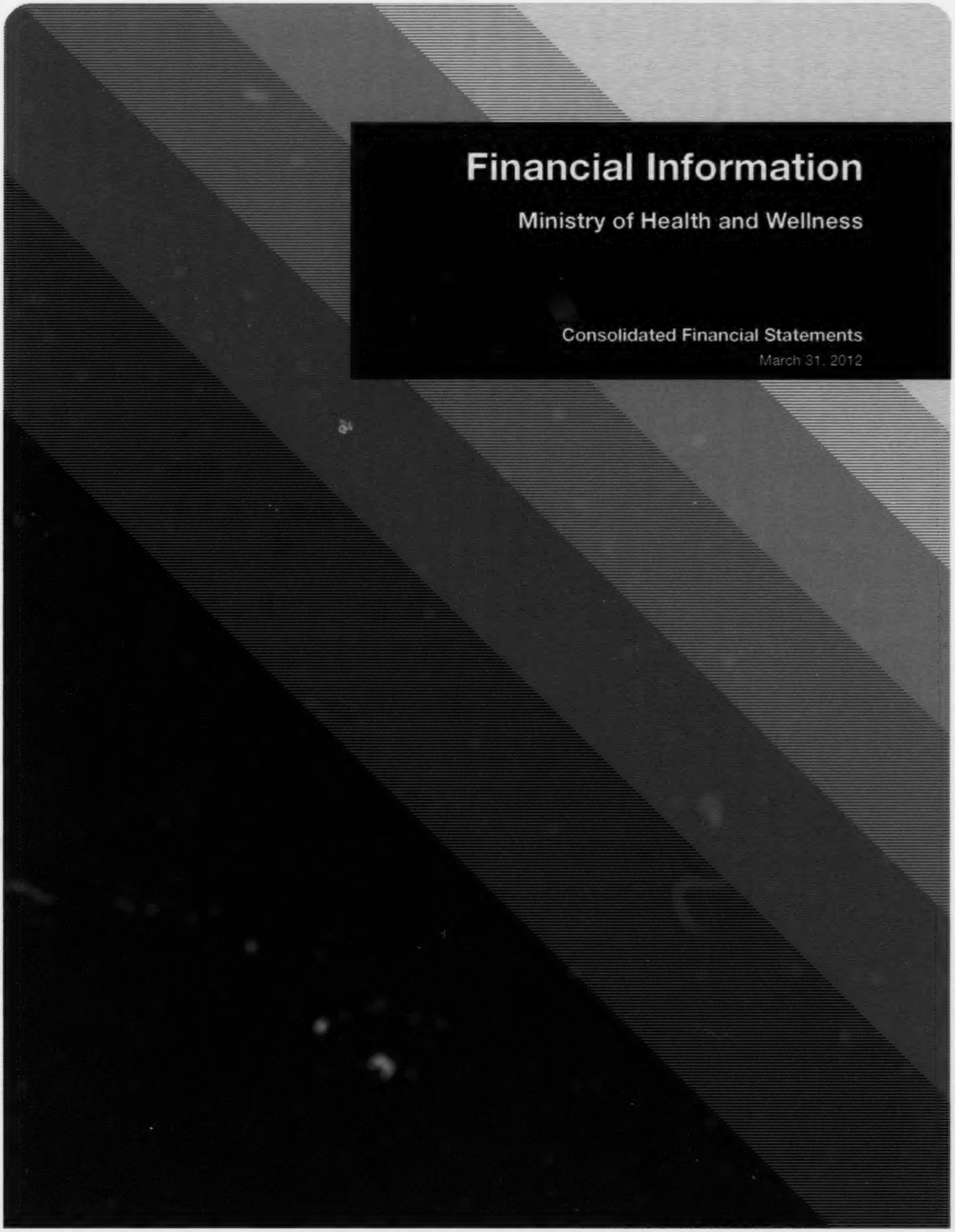
Health and Wellness

2011 – 2012 Funding Allocation

($ Millions)



Total — $14.8 Billion



Financial Information

Ministry of Health and Wellness

Consolidated Financial Statements

March 31, 2012

Ministry of Health and Wellness

Consolidated Financial Statements

March 31, 2012

Consolidated Financial Statements
March 31, 2012

Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 - Consolidated Revenues

Schedule 2 - Consolidated Expenses-Directly Incurred Detailed by Object

Schedule 3 - Reconciliation of Budget with Actuals

Schedule 4 - Consolidated Related Party Transactions

Schedule 5 - Consolidated Allocated Costs

Schedule 6 - Consolidated Portfolio Investments

AUDITOR
GENERAL
Alberta

Independent Auditor's Report

To the Members of the Legislative Assembly

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of the Ministry of Health and Wellness, which comprise the consolidated statement of financial position as at March 31, 2012, and the consolidated statements of operations and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Ministry as at March 31, 2012, and the results of its operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 7, 2012

Edmonton, Alberta

Consolidated Statement of Operations

Year Ended March 31, 2012

(in thousands)

	2012	2011 (Restated - Note 3)
Revenues (Schedule 1)		
Internal Government Transfers	$ 756,439	$ 690,520
Transfers from Government of Canada	2,191,864	2,215,114
Premiums, Fees and Licences	508,134	494,304
Investment Income	42,566	62,761
Other Revenue	626,704	567,346
	4,125,707	4,030,045
Expenses - Directly Incurred (Note 2b(iv) and Schedules 2,3 & 5)		
Physician Compensation and Development	3,474,205	3,176,218
Drugs and Supplemental Health Benefits	763,492	751,780
Community Programs and Healthy Living	398,448	367,749
Support Programs	178,050	220,408
Facility Based Patient Care	4,697,312	4,295,179
Community Based & Home Care	1,348,274	1,189,170
Diagnostic,Therapeutic & Other Patient Services	2,523,250	2,417,910
Research and Education	121,930	142,891
Health Service Delivery Support	1,546,503	1,502,256
Administration & Support Services	944,693	851,523
Other	205,982	199,091
	16,202,139	15,114,175
Net Operating Results	$ (12,076,432)	$ (11,084,130)

The accompanying notes and schedules are part of these consolidated financial statements.

Consolidated Statement of Financial Position

As at March 31, 2012
(in thousands)

	2012	2011 (Restated - Note 3)
ASSETS		
Cash and Cash Equivalents (Note 5)	$ 842,225	$ 508,511
Portfolio Investments (Schedule 6)	1,508,109	2,014,300
Accounts Receivable (Note 6)	599,561	574,550
Tangible Capital Assets (Note 7)	7,307,509	6,799,128
Inventories	119,392	120,250
Prepaid Expenses	71,311	75,197
	$ 10,448,107	$ 10,091,936
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 8)	$ 2,221,995	$ 1,973,765
Deferred Revenue (Note 9)	453,343	672,742
Notes, Debentures and Mortgages (Note 10)	369,979	336,299
	3,045,317	2,982,806
NET ASSETS		
Net Assets at Beginning of Year	7,109,130	5,765,376
Adjustment to Opening Net Assets (Note 4)	(102,560)	-
Net Operating Results	(12,076,432)	(11,084,130)
Net Financing provided from General Revenues	12,472,652	12,427,884
Net Assets at End of Year (Note 13)	7,402,790	7,109,130
	$ 10,448,107	$ 10,091,936

Contractual Obligations and Contingent Liabilities (Notes 11 and 12)

The accompanying notes and schedules are part of these consolidated financial statements.

Consolidated Statement of Cash Flows

Year Ended March 31, 2012
(in thousands)

	2012	2011 (Restated - Note 3)
Operating Transactions		
Net Operating Results	$ (12,076,432)	$ (11,084,130)
Non-cash items:		
Amortization of Tangible Capital Assets and Consumption of Inventories (Schedule 2)	1,097,837	1,143,946
Grants in kind (Note 7)	(495,328)	(105,966)
Write-down of Tangible Capital Assets / Inventories	5,714	7,976
Valuation Adjustments and write-downs	82,110	27,937
Loss (Gain) on disposal of Portfolio Investments	21,871	(22,716)
	(11,364,228)	(10,032,953)
(Increase) in Accounts Receivable	(72,329)	(313,882)
Decrease (Increase) in Prepaid Expenses	1,186	(18,709)
Increase in Accounts Payable and Accrued Liabilities	113,578	197,547
(Decrease) in Deferred Revenue	(219,399)	(499,601)
Cash (applied to) Operating Transactions	(11,541,192)	(10,667,598)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 7)	(502,835)	(908,797)
Purchase of Inventories	(612,911)	(658,560)
Cash (applied to) Capital Transactions	(1,115,746)	(1,567,357)
Investing Transactions		
Purchase of Portfolio Investments	(2,951,867)	(7,485,980)
Proceeds on sale of Portfolio Investments	3,436,187	6,039,341
Cash provided by (applied to) Investing Transactions	484,320	(1,446,639)
Financing Transactions		
Net Financing provided from General Revenues	12,472,652	12,427,884
Principal payments of Notes, Debentures and Mortgages	(160,320)	(12,565)
Proceeds from Notes, Debentures and Mortgages	194,000	73,160
Cash provided by Financing Transactions	12,506,332	12,488,479
Increase (Decrease) in Cash	333,714	(1,193,115)
Cash, Beginning of Year	508,511	1,701,626
Cash, End of Year	$ 842,225	$ 508,511

The accompanying notes and schedules are part of these consolidated financial statements.

Notes to the Consolidated Financial Statements

March 31, 2012

Note 1 Authority and Purpose

The Minister of Health and Wellness (Minister) has been designated responsibilities for various Acts by the *Government Organization Act*. To fulfill these responsibilities, the Minister administers the organizations listed below. The authority under which each organization operates is also listed. Together these organizations form the Ministry of Health and Wellness (Ministry).

Department of Health and Wellness	*Government Organization Act*
Alberta Health Services	*Regional Health Authorities Act*
Health Quality Council of Alberta	*Health Quality Council of Alberta Act*
Calgary Health Trust	*Regional Health Authorities Act*
Alberta Cancer Foundation	*Regional Health Authorities Act*

The purpose of the Ministry is to maintain and improve the health of Albertans by providing increased access to quality health care and improve the efficiency and effectiveness of health care service delivery. The Ministry is also engaged in inter-ministerial initiatives to effectively address challenges to the health and well-being of the population.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian Public Sector Accounting Standards.

(a) Reporting Entity and method of consolidation

The reporting entity is the Ministry of Health and Wellness, for which the Minister of Health and Wellness is accountable. These financial statements include the accounts of the following entities:

Department of Health and Wellness
Alberta Health Services (AHS)
Health Quality Council of Alberta (HQCA)
Calgary Health Trust
Alberta Cancer Foundation

The accounts of the above entities are consolidated on line-by-line basis after adjusting them to a basis consistent with the accounting policies described below. Revenue and expense transactions, capital, and financing transactions, and related asset and liability balances between the consolidated entities have been eliminated.

The threshold for recognizing inter-entity transactions among SUCH (Schools, Universities, Colleges and Hospitals) sector entities and between SUCH sector entities and other government controlled entities is $1,000,000 for particular transaction types and balances. Transactions involving school boards are subject to a $100,000 threshold for particular transaction types and balances.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(a) Reporting Entity and method of consolidation (continued)

The Ministry has entered into various partnerships with one or more partners outside the reporting entity to establish Primary Care Networks. The Ministry has also entered into a partnership with the University of Alberta to establish the Northern Alberta Clinical Trials Centre. The Ministry and its partners share, on an equitable basis, the significant risks and benefits associated with operating the partnership. The Ministry's 50 per cent interests in these partnerships are included in these financial statements under the proportionate consolidation method. The Ministry includes its proportionate share of assets, liabilities, revenues and expenses on a line-by-line basis, after conforming the accounting policies and eliminating its proportionate share of the balances and transactions with the partnerships.

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided or used for purposes specified by year end is recorded as unearned revenue or included in accounts payable and accrued liabilities.

(ii) Internal Government Transfers

Internal government transfers are transfers between entities within the government reporting entity where the entity making the transfer does not receive any goods or services directly in return. Restricted internal government transfers are reported as liabilities and included in deferred revenue until the transfer is used for the purposes specified. Unrestricted internal government transfers are recognized in revenue when received or receivable. Transfer of tangible capital assets work-in-progress is recognized as revenue as costs are incurred and work-in-progress reported by the Department of Infrastructure.

(iii) Transfers from Government of Canada

Transfers from Government of Canada are recognized as revenues when authorized by federal legislation or federal/provincial agreements, eligibility criteria, if any, are met and a reasonable estimate of the amounts can be made. Overpayments relating to Canada Health Transfers entitlements and other transfers received before revenue recognition criteria have been met are included in either accounts payable and accrued liabilities or deferred revenue.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

(iv) Expenses

Directly Incurred

Directly incurred expenses are those costs for which the Ministry has primary responsibility and accountability for.

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets.
- consumption of inventories.
- pension costs, which are the cost of employer contributions for current service of employees during the year.
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation and sick pay.

Grants are recognized as expenses when authorized, eligibility criteria, if any, are met, and a reasonable estimate of the amounts can be made.

Incurred by Others

Services contributed by other entities in support of the Ministry's operations are not recognized and are disclosed in Schedule 4 and 5.

(v) Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial assets of the Ministry are limited to cash and financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Assets acquired by right are not included. Tangible capital assets of the Ministry are recorded at historical cost which includes all amounts directly attributable to the acquisition, construction, development or betterment of the asset. The costs of tangible capital assets built on behalf of the Ministry by the Department of Infrastructure are recorded as costs are incurred and work-in-progress reported by the Department of Infrastructure. Tangible capital assets are amortized on a straight-line basis over the estimated useful life of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major systems enhancements is $100,000. The threshold for all other tangible capital assets is $5,000. All land is capitalized.

Amortization is only charged if the tangible capital asset is in use.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

Inventories are valued at the lower of cost and net realizable value. Cost is determined on a first-in, first-out basis.

(vi) Liabilities

Liabilities are recorded to the extent that they represent present obligations as a result of events and transactions occurring prior to the end of the fiscal year. The settlement of liabilities will result in sacrifice of economic benefits in the future.

(vii) Net Assets

Net assets represent the difference between the carrying value of assets held by the Ministry and its liabilities.

Canadian public sector accounting standards require a "net debt" presentation for the statement of financial position in the summary financial statements of governments. Net debt presentation reports the difference between financial assets and liabilities as "net debt" or "net financial assets" as an indicator of the future revenues required to pay for past transactions and events. The Ministry operates within the government reporting entity, and does not finance all its expenditures by independently raising revenues. Accordingly, these financial statements do not report a net debt indicator.

(viii) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash and cash equivalents, accounts receivable, advances, accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

The fair values of bonds and mortgages and equities are valued at the average of the latest bid and ask prices.

The fair value of long term debt is estimated based on market interest rates from Alberta Capital Finance Authority (ACFA) for debentures of similar maturity.

(ix) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of Canada Health Transfer.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

(ix) Measurement Uncertainty (continued)

Measurement uncertainty for the Canada Health Transfer relates to the tax transfer component. The current value of income tax points (personal and corporate) transferred historically by the federal government are used to adjust the entitlements. The value of the tax transfer amounts is unknown at year end because the tax years have not been assessed yet. Accordingly, these amounts are estimated and could change by a material amount.

Note 3 Reporting Changes and Prior Period Adjustments

(in thousands)

The following is a summary of the effect of the Reporting Changes and Prior Period Adjustments:

	March 31, 2011				
		Reporting Changes			
	As Previously Reported	Program Transfer from Ministry of Seniors	Lottery Fund Initiatives [1]	Full Cost Adjustments [2]	As Restated
Revenues	$ 4,644,193	$ -	$ (420,497)	$ (193,651)	$ 4,030,045
Expenses	(15,307,586)	(240)	-	193,651	(15,114,175)
Net Operating Results	(10,663,393)	(240)	(420,497)	-	(11,084,130)
Net Financing Provided From General Revenues	12,007,147	240	420,497	-	12,427,884
Net Assets at March 31, 2010	5,765,376	-	-	-	5,765,376
Net Assets at March 31, 2011	$ 7,109,130	$ -	$ -	$ -	$ 7,109,130

(1) The method of funding the eligible initiatives from the lottery and gaming proceeds was changed during the year. Previously, they were funded directly from the Lottery Fund and were included in the Ministry's revenues. However, such proceeds are now deposited into the General Revenue Fund to finance the eligible initiatives. Financial statements for prior years have been restated as if the current arrangement had always existed.

(2) AHS previously reported fees and charges on a gross up basis for revenues earned by voluntary health service providers. An equivalent amount was recorded as program expenses. For the year ended March 31, 2012 these revenues and expenses are no longer grossed up for reporting purposes. This change has been applied retroactively with restatement.

Note 4 Net Assets

(in thousands)

The opening net assets were retroactively adjusted for accrual of accumulated non-vested sick leave obligations for certain employee groups at Alberta Health Services. The liability of $85,441 related to these benefits was actuarially determined.

Forgivable loans were considered as grants in the consolidated Ministry financial statements when amounts were advanced to contracted health service providers. During the year, Alberta Health Services changed its accounting policy for forgivable loans to be consistent with the Ministry. As a result, additional forgivable loans of $17,119 from prior years were identified during the year. These amounts were adjusted against the opening net assets.

Had these adjustments been reflected in prior years, the net assets of the Ministry would have decreased by $102,560.

Note 5 Cash and Cash Equivalents

Cash and cash equivalents is comprised of Canadian dollar operating accounts, term deposits, money market funds and deposits in Consolidated Cash Investment Trust Fund (CCITF) of the Province of Alberta.

The CCITF is a demand account managed by Alberta Finance with the objective of providing competitive interest income to depositors while maintaining security and liquidity of depositors' capital. Interest is earned on the daily cash balance and the average rate of earnings of the CCITF varies depending on prevailing market interest rates. At March 31, 2012, deposits in CCITF had a time-weighted return of 1.3% per annum (2011-1.1% per annum).

Note 6 Accounts Receivable

(in thousands)

	2012			2011
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 513,676	$ (33,499)	$ 480,177	$ 480,722
Other Receivable	119,384	-	119,384	93,828
Total	$ 633,060	$ (33,499)	$ 599,561	$ 574,550

Accounts receivable are unsecured and non-interest bearing.

Note 7 Tangible Capital Assets
(in thousands)

	2012							2011
	Land	Buildings [1]	Land Improvements	Equipment	Computer Hardware and Software	Leasehold Assets	Total	Total
Estimated Used Life		10-40 years	5-40 years	2-20 years	3-10 years	Term of Lease		
Historical Cost [2]								
Beginning of year	$ 108,830	$ 7,783,175	$ 63,986	$ 1,752,073	$ 1,157,788	$ 177,056	$ 11,042,908	$ 10,106,240
Additions [3]	599	655,039	1,484	170,030	169,198	1,813	998,163	1,014,763
Disposals, including write-downs	-	-	-	(32,240)	(691)	(754)	(33,685)	(78,095)
	109,429	8,438,214	65,470	1,889,863	1,326,295	178,115	12,007,386	11,042,908
Accumulated Amortization								
Beginning of year	-	2,312,967	48,008	1,161,891	638,969	81,945	4,243,780	3,836,129
Amortization expense	-	196,846	2,295	141,407	120,553	25,848	486,949	481,874
Effect of disposals	-	-	-	(30,422)	(430)	-	(30,852)	(74,223)
	-	2,509,813	50,303	1,272,876	759,092	107,793	4,699,877	4,243,780
Net Book Value at March 31, 2012	$ 109,429	$ 5,928,401	$ 15,167	$ 616,987	$ 567,203	$ 70,322	$ 7,307,509	
Net Book Value at March 31, 2011	$ 108,830	$ 5,470,208	$ 15,978	$ 590,182	$ 518,819	$ 95,111		$ 6,799,128

[1] Buildings include parking lots.

[2] Historical cost includes work-in-progress at March 31, 2012 totaling $2,128,164 (2011 - $1,683,014)

[3] Additions include tangible capital assets totaling $495,328 (2011 - $105,966) transferred from the Department of Infrastructure at no cost (grants in kind).

Note 8 Accounts Payable and Accrued Liabilities

(in thousands)

	2012	2011
Accounts Payable and Accrued Liabilities	$ 1,699,925	$ 1,580,434
Accrued Vacation and Sick Pay	522,070	393,331
	$ 2,221,995	$ 1,973,765

The Ministry recognizes the fair value of the asset retirement obligations associated with tangible capital assets as liabilities. The asset retirement obligation is recognized when it is possible to estimate the fair value of the obligation. Adjustments are made at the end of each period to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes due to passage of time are reflected as an operating expense while changes in the estimated future cash flows is reflected as adjustments to the carrying value of the assets which are amortized over the remaining useful life of the assets.

Accounts payable and accrued liabilities above include asset retirement obligation of $4,852 (2011 - $11,058). The asset retirement obligation represents the legal obligation associated with the removal of asbestos during planned renovations at certain of the Ministry's health services facilities.

Note 9 Deferred Revenue

(in thousands)

	2012	2011
Deferred Contributions	$ 278,108	$ 328,099
Deferred Capital Contributions	167,280	327,879
Unearned Revenue	7,955	16,764
	$ 453,343	$ 672,742

Note 10 Notes, Debentures and Mortgages

(in thousands)

	Maturity	Interest Rate	2012 Carrying Value	2012 Fair Value	2011 Carrying Value	2011 Fair Value
Debentures [(a)]	2013 to 2032	4.23-4.93%	$ 335,699	$ 384,914	$ 180,971	$ 183,217
Bank Loan	2012	2.89%	19,000	19,000	140,000	140,000
			354,699	403,914	320,971	323,217
Capital Lease Obligation [(b)]	January 2028	6.50%	15,280	19,251	15,328	22,109
Total			$ 369,979	$ 423,165	$ 336,299	$ 345,326

[(a)] The debentures have been issued by AHS to ACFA.

[(b)] Capital Lease Obligation is with the University of Calgary.

Principal repayment requirements in each of the next five years and thereafter are as follows:

	Debentures and Bank Loan	Capital Lease Obligation	Total
2012-13	$ 38,286	$ 1,827	$ 40,113
2013-14	17,347	1,693	19,040
2014-15	14,533	1,532	16,065
2015-16	15,221	1,453	16,674
2016-17	15,943	1,453	17,396
Thereafter	253,369	16,845	270,214
Less: amount representing interest under leases	-	(9,523)	(9,523)
	$ 354,699	$ 15,280	$ 369,979

Note 11 Contractual Obligations

(in thousands)

Contractual obligations are obligations of the Ministry to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2012, the Ministry has the following contractual obligations:

	2012	2011
Specific Programs Commitments	$ 81,098	$ 102,638
Capital Contracts	256,527	317,282
Service Contracts and Operating Leases	312,653	280,463
	$ 650,278	$ 700,383

Note 11 Contractual Obligations (continued)

(in thousands)

The aggregate amounts payable for the unexpired terms of these contractual obligations are as follows:

	Specific Programs Commitments	Capital Contracts	Service Contracts and Operating Leases	Total
2013	$ 53,399	$ 178,722	$ 106,816	$ 338,937
2014	9,851	77,753	54,622	142,226
2015	4,613	4	45,937	50,554
2016	4,316	4	25,744	30,064
2017	4,230	4	20,808	25,042
Thereafter	4,689	40	58,726	63,455
	$ 81,098	$ 256,527	$ 312,653	$ 650,278

Canadian Blood Services

The Government of Alberta is committed to provide funding to the Canadian Blood Services (CBS) for the provision of blood services in Canada. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $151,732 (2011 - $157,857).

Note 12 Contingent Liabilities and Equity Agreements

(in dollars)

Hepatitis C

In June 1999, the Federal, provincial and territorial governments entered into an agreement to provide financial assistance to Canadians who were affected by the Hepatitis C virus through the Canadian blood system during the period from January 1, 1986 to July 1, 1990. The agreement provided for a total federal, provincial and territorial contribution of $1.1 billion plus interest. Interest is calculated and accrued quarterly on the outstanding balance at a rate equal to the three month Government of Canada Treasury Bill rate for the quarter. In the fiscal year 1999/2000, the Ministry accrued $30 million; representing Alberta's estimated proportionate share of the financial assistance, excluding accrued interest. At March 31, 2012, the outstanding balance, including Alberta's proportionate share of the accrued interest, was $16.9 million (2011-$17.9 million).

Note 12 Contingent Liabilities and Equity Agreements (continued)

(in dollars)

Equity Agreements with Voluntary Hospital Owners

The Ministry has a contingent liability for buy-out of equity under Equity Agreements entered into between the Ministry and Voluntary Hospital Owners. The Ministry's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2012, the contingent payout liability upon termination is estimated at $12.8 million (2011 - $12.8 million).

Other Contingent Liabilities

At March 31, 2012, the Ministry was named as defendant in 191 legal actions; the outcome of which is indeterminable (2011 - 129 legal actions). One hundred and fifty seven of these claims have specified amounts totaling $299.5 million and the remaining 34 have no specified amounts (2011 - 94 claims with specified amount of $399.0 million and 35 with no specified amount). Included in the total legal actions are 137 claims amounting to $184.5 million in which the Ministry has been jointly named with other entities and individuals (2011 - 80 claims amounting to $353.0 million). One hundred and thirty four claims amounting to $192.8 million are fully covered by either the Alberta Risk Management Fund or other insurance carriers (2011 - 108 claims amounting to $134.5 million). None of the claims are partially covered by Alberta Risk Management Fund (2011 - 1 claim amounting to $202.2 million). The resulting loss, if any, from these claims cannot be determined.

Indemnity

As described in Note 11, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250.0 million with respect to risks associated with the operation of the blood system.

Effective September 28, 2006, CBSE has entered into an agreement whereby the provinces (except Quebec) and territories guarantee and indemnify the risks of operation of the blood system in the amount of $750.0 million in excess of the $250.0 million provided by the insurance coverage from CBSI. Alberta's pro rata share of the $750.0 million is 13.1 per cent or $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2012, no amount has been recognized for this indemnity.

Note 13 Endowment Funds

(in thousands)

Endowment funds are included in net assets and are represented by financial assets amounting to $60,234 (2011 - $57,032). Donors have placed restrictions on their contributions to the endowment funds. The principal restriction is that the original contribution should not be spent.

Note 14 Trust Funds under Administration

(in thousands)

Trust funds under administration are funds consisting of public money over which the Legislature has no power of appropriation. Because the Ministry has no equity in the funds and administers them for the purposes of various trusts, they are not included in the consolidated financial statements. As at March 31, 2012, trust funds under administration were as follows:

	2012	2011
Research and development, education and others	$ 9,308	$ 7,263

Note 15 Benefit Plans

(in thousands)

Except as noted below, the Ministry participates in the multi-employer pension plans: Management Employees Pension Plan (MEPP), Public Service Pension Plan (PSPP) and Supplementary Executive Retirement Plans (SERPs) for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions.

Certain consolidated entities participate in the Local Authorities Pension Plan (LAPP), which is a multi-employer defined benefit plan. The pension expense for this plan is equivalent to the annual contributions. These entities also provide defined supplementary executive retirement plans for certain management staff. The cost of these benefits is actuarially determined on an annual basis using the projected benefit method pro-rated on services, a market interest rate, and management's best estimate of expected costs and the period of benefit coverage. At March 31, 2012, SERP plans have net accrued benefit asset of $11,660 (2011 - $12,539). The accrued benefit asset is included in prepaid expenses.

In addition, Alberta Health Services also participates in defined contribution plans and Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups.

At December 31, 2011, the Management Employees Pension Plan reported a deficiency of $517,726 (2010 - $397,087), the Public Service Pension Plan reported a deficiency of $1,790,383 (2010 - $2,067,151), the Local Authorities Pension Plan reported a deficiency of $4,639,390 (2010 - $4,635,250) and the Supplementary Retirement Plan for Public Service Managers had a deficiency of $53,489 (2010 - $39,559).

Note 15 Benefit Plans (continued)

(in thousands)

Ministry's pension expense for the year is as follows:

	2012	2011
Registered Benefit Plans	$ 371,092	$ 330,139
SERPs	3,770	3,357
Defined Contribution Plans and GRRSPs	17,295	13,380
Expense of transferring PSPP service to LAPP	5,169	-
	$ 397,326	$ 346,876

The Ministry also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2012, the Bargaining Unit Plan reported an actuarial surplus of $9,136 (2011 - deficiency $4,141) and the Management, Opted Out and Excluded Plan reported an actuarial surplus of $10,454 (2011 - $7,020). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 16 Comparative Figures

Certain 2011 figures have been reclassified to conform to the 2012 presentation.

Note 17 Subsequent Events

On May 8, 2012, the government announced cabinet restructuring. As a result, the Ministry of Seniors was disestablished and certain programs and services as prescribed by Order in Council 155/2012 were transferred to Ministry of Health and Wellness. The Ministry was renamed as "Ministry of Health".

Note 18 Approval of Financial Statements

The financial statements were approved by the Senior Financial Officer and the Deputy Minister.

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2012

Schedule 1
Consolidated Revenues
(in thousands)

	2012	2011 (Restated - Note 3)
Internal Government Transfers		
Transfer from Alberta Cancer Prevention Legacy Fund	$ 22,481	$ 18,750
Transfer from Other Government Departments	733,958	671,770
	756,439	690,520
Transfers from Government of Canada		
Canada Health Transfer	2,155,449	2,175,791
Wait Times Reduction	27,379	27,262
Other Health Transfers	9,036	12,061
	2,191,864	2,215,114
Premiums, Fees and Licences		
Supplementary Health Benefit Premiums	56,174	57,910
Fees and Charges	451,932	436,269
Other	28	125
	508,134	494,304
Investment Income	42,566	62,761
Other Revenue		
Third Party Recoveries	96,151	94,601
Previous years' refunds of expenditure	32,322	27,253
Donations	139,628	126,346
Miscellaneous	358,603	319,146
	626,704	567,346
Total Revenues	$ 4,125,707	$ 4,030,045

Schedules to the Consolidated Financial Statements
Year Ended March 31, 2012

Schedule 2
Consolidated Expenses - Directly Incurred Detailed by Object
(in thousands)

	2012	2011
		(Restated - Note 3)
Grants	$ 4,594,574	$ 4,435,108
Supplies and Services	4,339,443	3,867,350
Salaries, Wages and Employee Benefits	6,116,525	5,649,161
Amortization of Tangible Capital Assets	486,949	481,874
Consumption of Inventories	610,888	662,072
Financial Transactions and Other	53,760	18,610
	$ 16,202,139	$ 15,114,175

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2012

Schedule 3
Reconciliation of Budget with Actuals

(in thousands)

	Budget	Actual without SUCH* sector	Actual SUCH sector	Adjustments	Actual with SUCH sector
REVENUES					
Internal Government Transfers					
Transfer from Alberta Cancer Prevention Legacy Fund	$ 25,000	$ 22,481	$ -	$ -	$ 22,481
Transfer from Alberta Health and Wellness / Other Government Departments	-	-	10,615,001	(9,881,043)	733,958
	25,000	22,481	10,615,001	(9,881,043)	756,439
Transfers from Government of Canada					
Canada Health Transfer	2,266,219	2,155,449	-	-	2,155,449
Wait Times Reduction	27,356	27,379	-	-	27,379
Other Health Transfers	8,113	9,036	-	-	9,036
	2,301,688	2,191,864	-	-	2,191,864
Premiums, Fees and Licenses					
Supplementary Health Benefit Premiums	57,603	56,174	-	-	56,174
Fees and Charges	-	-	451,932	-	451,932
Other	6	28	-	-	28
	57,609	56,202	451,932	-	508,134
Investment Income	-	-	39,015	3,551	42,566
Other Revenue					
Third Party Recoveries	95,500	96,151	-	-	96,151
Previous years' refunds of expenditure	-	62,745	-	(30,423)	32,322
Donations	-	-	117,919	21,709	139,628
Miscellaneous	654	24,983	678,110	(344,490)	358,603
	96,154	183,879	796,029	(353,204)	626,704
Total Revenues	$ 2,480,451	$ 2,454,426	$ 11,901,977	$ (10,230,696)	$ 4,125,707
EXPENSES					
Grants	14,657,290	14,615,017	387,371	(10,407,814)	4,594,574
Supplies and Services	134,819	91,213	4,300,870	(52,640)	4,339,443
Salaries, Wages and Employee Benefits	78,152	76,047	6,042,785	(2,307)	6,116,525
Amortization of Tangible Capital Assets	17,500	15,031	471,918	-	486,949
Consumption of Inventories	57,291	39,613	571,275	-	610,888
Financial Transactions and Other	2,268	6,486	47,274	-	53,760
Total Expenses	$ 14,947,320	$ 14,843,407	$ 11,821,493	$ (10,462,761)	$ 16,202,139

* SUCH - Schools, Universities, Colleges and Hospitals.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2012

Schedule 4
Consolidated Related Party Transactions

(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's financial statements. Related parties also include management in the Ministry.

The Ministry and its employees paid or collected certain taxes and fees set by regulation for permits, licenses and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this Schedule.

The Ministry had the following transactions with related parties recorded in the Consolidated Statement of Operations and the Consolidated Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2012	2011 (Restated - Note 3)
Revenues		
Grants - Cancer Fund	$ 22,481	$ 18,750
- Alberta Infrastructure	656,249	623,317
- Others	77,034	41,075
Other	27,516	45,415
	$ 783,280	$ 728,557
Expenses - Directly Incurred		
Grants	$ 112,816	$ 202,987
Other	148,236	140,481
Interest	9,009	7,954
	$ 270,061	$ 351,422
Receivables	$ 105,049	$ 58,924
Payables-Alberta Infrastructure	$ 267,282	$ 347,609
-Other Ministries	33,175	41,293
	$ 300,457	$ 388,902
Debt to Related Parties	$ 352,333	$ 195,865
Contractual Obligations	$ 44,857	$ 45,571

The Ministry receives services under contracts managed by Service Alberta. Any commitments under these contracts are reported by Service Alberta.

The Ministry also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not recorded in the consolidated financial statements and are disclosed in Schedule 5.

	2012	2011
Expenses - Incurred by Others		
Accommodation	$ 38,613	$ 31,535
Legal	3,224	2,678
Other	8,415	8,097
	$ 50,252	$ 42,310

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2012

Schedule 5

Consolidated Allocated Costs

(in thousands)

	2012					2011
		Expenses - Incurred by Others				(Restated - Note 3)
Program	Expenses [1]	Accommodation Costs [2]	Legal Services [3]	Other Cost [4]	Total	Total
Physician Compensation and Development	$ 3,474,205	$ -	$ -	$ -	$ 3,474,205	$ 3,176,218
Drugs and Supplemental Health Benefits	763,492	-	-	-	763,492	751,780
Community Programs and Healthy Living	398,448	-	-	-	398,448	367,935
Support Programs	178,050	-	-	-	178,050	220,408
Facility Based Patient Care	4,697,312	9,987	-	-	4,707,299	4,302,915
Community Based & Home Care	1,348,274	11,414	-	-	1,359,688	1,198,102
Diagnostic,Therapeutic & Other Patient Services	2,523,250	268	-	-	2,523,518	2,417,910
Research and Education	121,930	-	-	-	121,930	142,891
Health Service Delivery Support	1,546,503	-	-	-	1,546,503	1,506,049
Administration & Support Services	944,693	16,944	3,224	8,415	973,276	873,186
Other	205,982	-	-	-	205,982	199,091
	$ 16,202,139	$ 38,613	$ 3,224	$ 8,415	$ 16,252,391	$ 15,156,485

[1] Expenses - Directly Incurred as per Statement of Operations.

[2] Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 4.

[3] Costs shown for Legal Services on Schedule 4.

[4] Other Costs includes services the Ministry receives under contracts managed by Service Alberta shown on Schedule 4.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2012

Schedule 6
Consolidated Portfolio Investments

(in thousands)

	2012		2011	
	Book Value	Fair Value	Book Value	Fair Value
Interest bearing securities [(a)]				
Deposits and short-term securities	$ 75,047	$ 75,047	$ 640,632	$ 640,765
Bonds and mortgages	1,339,075	1,348,967	1,285,259	1,276,791
	1,414,122	1,424,014	1,925,891	1,917,556
Equities:				
Canadian public equities	34,509	42,446	29,683	40,510
Global developed public equities	18,992	18,912	18,030	18,621
Pooled investment funds	37,728	37,534	36,655	38,039
Others	2,758	4,340	4,041	5,452
	93,987	103,232	88,409	102,622
Total	$ 1,508,109	$ 1,527,246	$ 2,014,300	$ 2,020,178

The majority of Portfolio Investments are held by AHS. In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for deposits and short-term securities, 0% to 80% for bonds and mortgages, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class, and quality constraints on interest bearing securities and equity investments.

a) Interest Rate Risk

The interest rate risk exposure of its interest bearing securities is managed by the management of average duration and laddered maturity dates.

Deposits and short-term securities are comprised of Government of Canada, provincial and corporate treasury bills maturing June 2012 and bearing interest at an average effective yield of 0.97% (2011 – 0.74%) per annum.

Schedules to the Consolidated Financial Statements

Year Ended March 31, 2012

Schedule 6 (continued)

Bonds and mortgages have an average effective market yield of 1.80% (2011 – 2.07%) per annum and the following is the maturity structure based on principal amount.

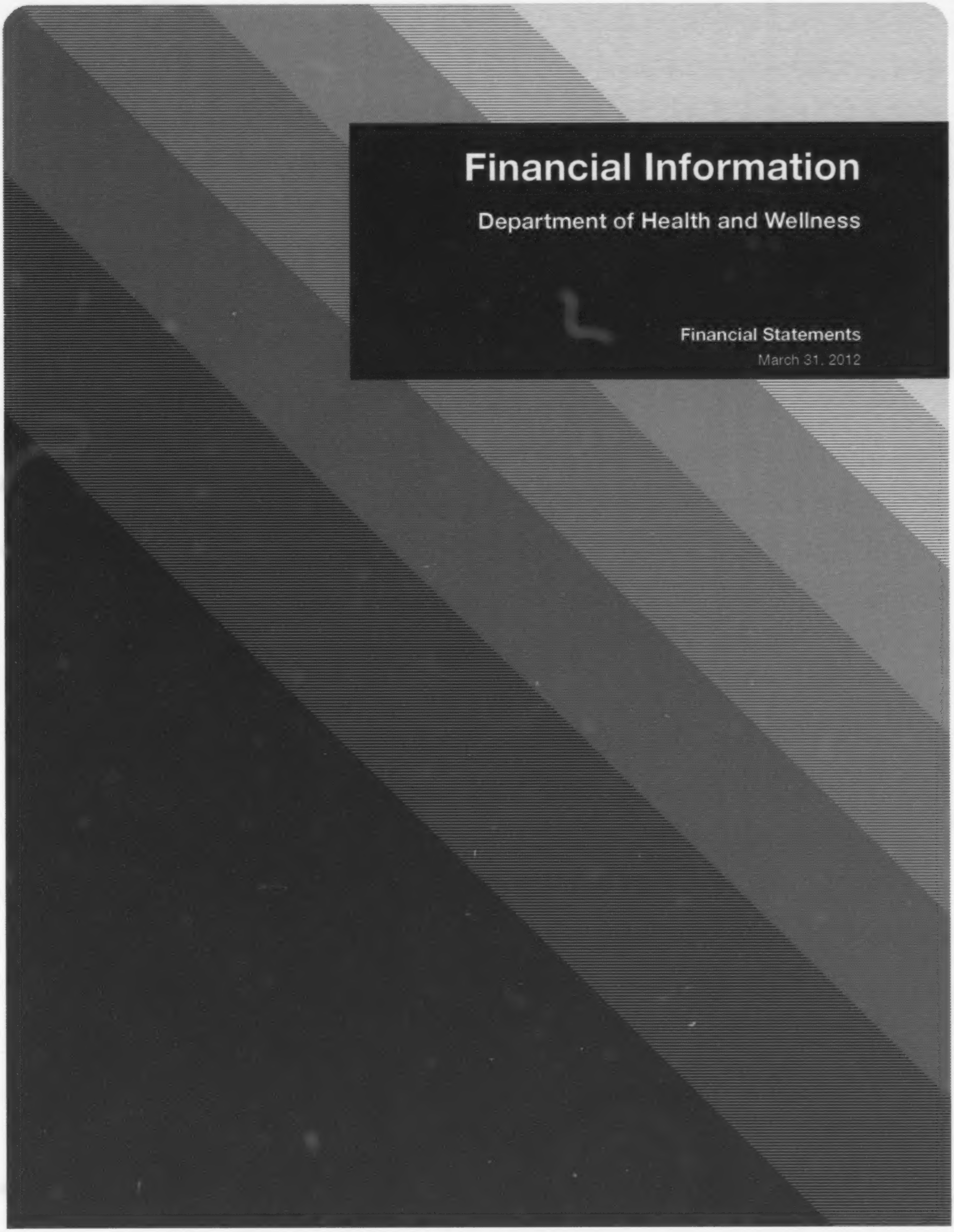
	2012	2011
Under 1 Year	1%	2%
1 to 5 years	85%	85%
6 to 10 years	11%	10%
Over 10 years	3%	3%

b) Currency Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is mitigated by the fact that AHS's investment bylaw limits non-Canadian equities to 25% of the total investment portfolio.

c) Credit and Market Risks

AHS's investment bylaw restricts the types and proportions of eligible investments. Investments in deposits and short-term securities are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income investments. Investment in debt and equity of any issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.



Financial Information

Department of Health and Wellness

Financial Statements

March 31, 2012

Department of Health and Wellness

Financial Statements

March 31, 2012

Financial Statements
March 31, 2012

Auditor's Report

Statement of Operations

Statement of Financial Position

Statement of Cash Flows

Notes to the Financial Statements

Schedule 1 - Revenues

Schedule 2 - Credit or Recovery Initiatives

Schedule 3 - Expenses Directly Incurred Detailed by Object

Schedule 4 - Budget

Schedule 5 - Comparison of Directly Incurred Expenses and Capital Investment by Element to Authorized Spending

Schedule 6 - Lottery Fund Estimates

Schedule 7 - Salaries and Benefits

Schedule 8 - Related Party Transactions

Schedule 9 - Allocated Costs

AUDITOR
GENERAL
Alberta

Independent Auditor's Report

To the Minister of Health

Report on the Financial Statements

I have audited the accompanying financial statements of the Department of Health and Wellness, which comprise the statement of financial position as at March 31, 2012, and the statements of operations and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Department as at March 31, 2012, and the results of its operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 7, 2012

Edmonton, Alberta

STATEMENT OF OPERATIONS

Year Ended March 31, 2012
(in thousands)

	2012		2011
	Budget (Schedule 4)	Actual	Actual (Restated - Note 3)
Revenues (Schedule 1)			
Internal Government Transfers	$ 25,000	$ 22,481	$ 18,750
Transfers from Government of Canada	2,301,688	2,191,864	2,215,114
Premiums, Fees and Licences	57,609	56,202	58,035
Other Revenue	96,154	183,879	161,636
	2,480,451	2,454,426	2,453,535
Expenses - Directly Incurred (Note 2b(v) and Schedule 9)			
Program (Schedules 3 and 5)			
Ministry Support Services	57,803	46,568	45,337
Physician Compensation and Development	3,345,526	3,537,233	3,285,046
Allied Health Services	63,636	62,290	55,666
Human Tissue and Blood Services	158,902	152,303	160,239
Drugs and Supplemental Health Benefits	1,040,582	957,617	942,081
Community Programs and Healthy Living	178,118	122,541	119,550
Support Programs	250,232	158,594	317,995
Alberta Health Services	9,634,221	9,634,221	9,615,150
Health Quality Council of Alberta	4,026	4,026	3,623
Information Systems	130,174	104,666	102,015
Infrastructure Support	59,100	40,867	71,121
Cancer Research and Prevention Investment	25,000	22,481	18,750
	14,947,320	14,843,407	14,736,573
Net Operating Results	$ (12,466,869)	$ (12,388,981)	$ (12,283,038)

The accompanying notes and schedules are part of these financial statements.

STATEMENT OF FINANCIAL POSITION

As at March 31, 2012
(in thousands)

	2012	2011 (Restated - Note 3)
ASSETS		
Cash	$ 12,910	$ 4,328
Accounts Receivable (Note 4)	256,634	286,881
Tangible Capital Assets (Note 5)	91,817	91,255
Inventories	22,651	21,153
	$ 384,012	$ 403,617
LIABILITIES		
Accounts Payable and Accrued Liabilities (Note 6)	$ 455,363	$ 549,830
Unearned Revenue	7,955	16,764
	463,318	566,594
NET LIABILITIES		
Net Liabilities at Beginning of Year	(162,977)	(307,823)
Net Operating Results	(12,388,981)	(12,283,038)
Net Financing provided from General Revenues	12,472,652	12,427,884
Net Liabilities at End of Year	(79,306)	(162,977)
	$ 384,012	$ 403,617

Contractual Obligations and Contingent Liabilities (Notes 7 and 8)

The accompanying notes and schedules are part of these financial statements.

STATEMENT OF CASH FLOWS

Year Ended March 31, 2012
(in thousands)

	2012	2011 (Restated - Note 3)
Operating Transactions		
Net Operating Results	$ (12,388,981)	$ (12,283,038)
Non-cash items included in Net Operating Results:		
Amortization of Tangible Capital Assets and Consumption of Inventories	54,644	56,226
Valuation Adjustments and write-downs	5,984	6,937
	(12,328,353)	(12,219,875)
Decrease (Increase) in Accounts Receivable	26,977	(210,017)
(Decrease) Increase in Accounts Payable and Accrued Liabilities	(94,211)	79,998
(Decrease) in Unearned Revenue	(8,809)	(10,135)
Cash (applied to) Operating Transactions	(12,404,396)	(12,360,029)
Capital Transactions		
Acquisition of Tangible Capital Assets (Note 5)	(15,681)	(16,783)
Purchase of Inventories	(43,993)	(48,255)
Cash (applied to) Capital Transactions	(59,674)	(65,038)
Financing Transactions		
Net Financing Provided from General Revenues	12,472,652	12,427,884
Increase in Cash	8,582	2,817
Cash, Beginning of Year	4,328	1,511
Cash, End of Year	$ 12,910	$ 4,328

The accompanying notes and schedules are part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

Note 1 Authority and Purpose

The Department of Health and Wellness (the Department) operates under the authority of the *Government Organization Act*, Chapter G-10, Revised Statutes of Alberta 2000.

The purpose of the Department is to maintain and improve the health of Albertans by providing increased access to quality health care, improve the efficiency and effectiveness of health care service delivery and set policy and direction to lead, achieve and sustain a responsive, integrated and accountable health system.

The Department is also engaged in inter-ministerial initiatives to effectively address challenges to the health and well-being of the population.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian Public Sector Accounting Standards.

(a) Reporting Entity

The reporting entity is the Department of Health and Wellness, which is part of the Ministry of Health and Wellness and for which the Minister of Health and Wellness is accountable.

Other entities reporting to the Minister are Alberta Health Services (AHS) and its controlled entities, and the Health Quality Council of Alberta (HQCA). The financial results of these organizations are not included in these financial statements.

The Ministry Annual Report provides a comprehensive accounting of the financial position and results of the Ministry's operations for which the Minister is accountable.

All departments of the Government of Alberta operate within the General Revenue Fund (the Fund). The Fund is administered by the Minister of Finance. All cash receipts of departments are deposited into the Fund and all cash disbursements made by departments are paid from the Fund. Net Financing Provided from General Revenues is the difference between all cash receipts and all cash disbursements made.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting

(i) Revenues

All revenues are reported on the accrual basis of accounting. Cash received for which goods or services have not been provided by year end is recorded as unearned revenue.

(ii) Internal Government Transfers

Internal government transfers are transfers between entities within the government reporting entity where the entity making the transfer does not receive any goods or services directly in return. Internal government transfers are recognized as revenue when received or receivable.

(iii) Transfers from Government of Canada

Transfers from Government of Canada are recognized as revenues when authorized by federal legislation or federal/provincial agreements, eligibility criteria, if any, are met and a reasonable estimate of the amounts can be made. Overpayments relating to Canada Health Transfer entitlements and other transfers received before revenue recognition criteria have been met are included in either accounts payable and accrued liabilities or unearned revenue.

(iv) Credit or Recovery

Credit or recovery initiatives provide a basis for authorizing spending. Credit or recovery is shown in the details of the Government Estimates for a supply vote.

If budgeted revenues are not fully realized, spending is reduced by an equivalent amount. If actual credit or recovery amounts exceed budget, the Department may, with the approval of the Treasury Board, use the excess revenue to fund additional expenses of the program. Schedule 2 discloses information on the Department's credit or recovery initiatives.

(v) Expenses

Directly Incurred

Directly incurred expenses are those costs the Department has primary responsibility and accountability for, as reflected in the Government's budget documents.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

In addition to program operating expenses such as grants, salaries, supplies etc., directly incurred expenses also include:

- amortization of tangible capital assets.
- consumption of inventories.
- pension costs, which are the cost of employer contributions for current service of employees during the year.
- valuation adjustments which include changes in the valuation allowances used to reflect financial assets at their net recoverable or other appropriate value. Valuation adjustments also represent the change in management's estimate of future payments arising from obligations relating to vacation pay.

Grants are recognized as expenses when authorized, eligibility criteria, if any, are met, and a reasonable estimate of the amounts can be made.

Incurred by Others

Services contributed by other entities in support of the Department's operations are not recognized and are disclosed in Schedule 8 and Schedule 9.

(vi) Assets

Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not for consumption in the normal course of operations. Financial assets of the Department are limited to cash and financial claims, such as advances to and receivables from other organizations, employees and other individuals.

Assets acquired by right are not included. Tangible capital assets of the Department are recorded at historical cost which includes all amounts directly attributable to the acquisition, construction, development or betterment of the asset. Tangible capital assets are amortized on a straight-line basis over the estimated useful life of the assets. The threshold for capitalizing new systems development is $250,000 and the threshold for major systems enhancements is $100,000. The threshold for all other tangible capital assets is $5,000.

Amortization is only charged if the tangible capital asset is in use.

Inventories consist of vaccines and sera for distribution at no cost. Inventories are valued at the lower of cost and replacement cost on a first-in, first-out basis.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Basis of Financial Reporting (continued)

(vii) Liabilities

Liabilities are recorded to the extent that they represent present obligations as a result of events and transactions occurring prior to the end of the fiscal year. The settlement of liabilities will result in sacrifice of economic benefits in the future.

(viii) Net Liabilities

Net liabilities represent the difference between the carrying value of assets held by the Department and its liabilities.

Canadian public sector accounting standards require a "net debt" presentation for the statement of financial position in the summary financial statements of governments. Net debt presentation reports the difference between financial assets and liabilities as "net debt" or "net financial assets" as an indicator of the future revenues required to pay for past transactions and events. The department operates within the government reporting entity, and does not finance all its expenditures by independently raising revenues. Accordingly, these financial statements do not report a net debt indicator.

(ix) Valuation of Financial Assets and Liabilities

Fair value is the amount of consideration agreed upon in an arm's length transaction between knowledgeable, willing parties who are under no compulsion to act.

The fair values of cash, accounts receivable, accounts payable and accrued liabilities are estimated to approximate their carrying values because of the short-term nature of these instruments.

(x) Measurement Uncertainty

Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. Measurement uncertainty that is material to these financial statements exists in the accrual of Canada Health Transfer.

Measurement uncertainty for the Canada Health Transfer relates to the tax transfer component. The current value of income tax points (personal and corporate) transferred historically by the federal government are used to adjust the entitlements. The value of the tax transfer amounts is unknown at year end because the tax years have not been assessed yet. Accordingly, these amounts are estimated and could change by a material amount.

Note 3 **Reporting Changes**
(in thousands)

The following is a summary of the effect of the reporting changes:

	March 31, 2011			
		Reporting Changes		
	As Previously Reported	Program transfer from Department of Seniors	Lottery Fund Initiatives [1]	As Restated
Revenues	$ 2,874,032	$ -	$ (420,497)	$ 2,453,535
Expenses	(14,736,333)	(240)	-	(14,736,573)
Net Operating Results	(11,862,301)	(240)	(420,497)	(12,283,038)
Net Financing Provided From General Revenues	12,007,147	240	420,497	12,427,884
Net Liabilities at March 31, 2010	(307,823)	-	-	(307,823)
Net Liabilities at March 31, 2011	$ (162,977)	$ -	$ -	$ (162,977)

(1) The method of funding the eligible initiatives from the lottery and gaming proceeds was changed during the year. Previously, they were funded directly from the Lottery Fund and were included in the department's revenues. However, such proceeds are now deposited into the General Revenue Fund to finance the eligible initiatives. Financial statements for prior years have been restated as if the current arrangement had always existed. Schedule 6 provides a comparison of estimates and actual expenses for Lottery Fund initiatives.

Note 4 **Accounts Receivable**
(in thousands)

	2012			2011
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Accounts Receivable	$ 240,822	$ (1,600)	$ 239,222	$ 272,404
Amounts due from AHS	17,392	-	17,392	14,425
Other Receivable	20	-	20	52
	$ 258,234	$ (1,600)	$ 256,634	$ 286,881

Accounts receivable are unsecured and non-interest bearing.

Note 5 Tangible Capital Assets

(in thousands)

	2012			2011
	Equipment [1]	Computer Hardware and Software	Total	Total
Estimated Useful Life	10 years	5 - 10 years		
Historical Cost [2]				
Beginning of year	$ 2,375	$ 187,562	$ 189,937	$ 174,694
Additions	-	15,681	15,681	16,783
Disposals, including write-downs	(221)	-	(221)	(1,540)
	2,154	203,243	205,397	189,937
Accumulated Amortization				
Beginning of year	$ 1,230	$ 97,452	$ 98,682	$ 85,090
Amortization expense	219	14,812	15,031	13,701
Effect of disposals	(133)	-	(133)	(109)
	1,316	112,264	113,580	98,682
Net Book Value at March 31, 2012	$ 838	$ 90,979	$ 91,817	
Net Book Value at March 31, 2011	$ 1,145	$ 90,110		$ 91,255

[1] Equipment includes office equipment and furniture.

[2] Historical cost includes work-in-progress at March 31, 2012 for computer hardware and software totaling $18,283 (2011 - $13,800).

Note 6 Accounts Payable and Accrued Liabilities

(in thousands)

	2012	2011
Accounts payable	$ 81,663	$ 115,952
Accrued liabilities	287,151	222,513
Amounts due to AHS and HQCA	79,302	203,837
Accrued vacation pay	7,247	7,528
	$ 455,363	$ 549,830

Note 7 Contractual Obligations

(in thousands)

Contractual obligations are obligations of the Department to others that will become liabilities in the future when the terms of those contracts or agreements are met. As at March 31, 2012, the Department has the following contractual obligations:

	2012	2011
Specific Programs Commitments	$ 266,901	$ 388,693
Capital Contracts	7,473	12,792
Service Contracts	95,364	89,401
	$ 369,738	$ 490,886

The aggregate amounts payable for the unexpired terms of these contractual obligations are as follows:

	Specific Programs Commitments	Capital Contracts	Service Contracts	Total
2013	$ 221,962	$ 6,905	$ 60,828	$ 289,695
2014	20,442	516	19,726	40,684
2015	8,387	4	14,766	23,157
2016	7,942	4	20	7,966
2017	4,084	4	2	4,090
Thereafter	4,084	40	22	4,146
	$ 266,901	$ 7,473	$ 95,364	$ 369,738

Canadian Blood Services

The Government of Alberta is committed to provide funding to Canadian Blood Services (CBS) for the provision of blood services in Alberta. This commitment was outlined in a Memorandum of Understanding, signed in January 1998, which recorded the understandings and commitments of the Minister of Health of Canada and the Provincial and Territorial Ministers of Health (except Quebec) regarding their respective roles and responsibilities in a renewed national blood system.

Alberta's obligation for the operational costs of CBS is determined on a per capita basis, and the costs for fractionated blood and blood products is determined on the basis of annual utilization of these products. During the year, payments to CBS amounted to $151,732 (2011 - $157,857).

Note 8 Contingent Liabilities and Equity

(in dollars)

Hepatitis C

In June 1999, the Federal, provincial and territorial governments entered into an agreement to provide financial assistance to Canadians who were affected by the Hepatitis C virus through the Canadian blood system during the period from January 1, 1986 to July 1, 1990. The agreement provided for a total federal, provincial and territorial contribution of $1.1 billion plus interest. Interest is calculated and accrued quarterly on the outstanding balance at a rate equal to the three month Government of Canada Treasury Bill rate for the quarter. In the fiscal year 1999/2000, the Department accrued $30 million; representing Alberta's estimated proportionate share of the financial assistance, excluding accrued interest. At March 31, 2012, the outstanding balance, including Alberta's proportionate share of the accrued interest, was $16.9 million (2011 - $17.9 million).

Equity Agreements with Voluntary Hospital Owners

The Department has a contingent liability for buy-out of equity under Equity Agreements entered into between the Department and Voluntary Hospital Owners. The Department's payout liability is contingent upon notification by the voluntary hospital owner of termination of the equity agreement. At March 31, 2012, the contingent payout liability upon termination is estimated at $12.8 million (2011 - $12.8 million).

Other Contingent Liabilities

At March 31, 2012, the Department was named as defendant in thirty four legal actions, the outcome of which is indeterminable (2011 - nineteen legal actions). Twenty eight of these claims have specified amounts totaling $77.2 million and the remaining six have no specified amounts (2011 - twelve claims with a specified amount of $254.8 million and seven with no specified amount). Included in the total legal actions are twenty six claims amounting to $41.5 million (2011 - twelve claims amounting to $216.5 million) in which the Department has been jointly named with other entities and individuals. Four claims amounting to $2.1 million (2011 - five claims amounting to $4.7 million) are fully covered by the Alberta Risk Management Fund. None of the claims (2011 - one claim amounting to $202.2 million) are partially covered by Alberta Risk Management Fund. The resulting loss, if any, from these claims cannot be determined.

Indemnity

As described in Note 7, CBS provides blood services in Alberta. CBS has established two wholly-owned captive insurance corporations, CBS Insurance Company Limited (CBSI) and Canadian Blood Services Captive Insurance Company Limited (CBSE). CBSI provides insurance coverage up to $250.0 million with respect to risks associated with the operation of the blood system.

Effective September 28, 2006, CBSE has entered into an agreement whereby the provinces (except Quebec) and territories guarantee and indemnify the risks of operation of the blood system in the amount of $750.0 million in excess of the $250.0 million provided by the insurance coverage from CBSI. Alberta's pro rata share of the $750.0 million is 13.1% or $98.0 million. Authority for Alberta to provide the indemnity under the CSA is pursuant to section 5.05 of the Indemnity Authorization Regulation 22/1997, under the *Financial Administration Act*.

The expense recognition criterion for the indemnity is notification from CBS that the indemnity is required. At March 31, 2012, no amount has been recognized for this indemnity.

Note 9 **Payments under Reciprocal and Other Agreements**
(in thousands)

The Department entered into agreements, under the Alberta Health Care Insurance Plan, with other Provincial and Territorial Governments, the Royal Canadian Mounted Police (RCMP), Health Canada and the Workers' Compensation Board to provide health services on their behalf. The Department pays service providers for services rendered under the agreements and recovers the amount paid from the program sponsors. Service providers include Alberta Health Services and physicians. Costs under these agreements are incurred by the Department under authority in section 25 of the *Financial Administration Act*.

Accounts receivable under agreements with program sponsors as at March 31, 2012 is $39,154 (2011- $25,236).

Note 10 **Benefit Plans**
(in thousands)

The Department participates in the multi-employer pension plans: Management Employees Pension Plan, Public Service Pension Plan and Supplementary Retirement Plan for Public Service Managers. The expense for these pension plans is equivalent to the annual contributions of $8,314 for the year ended March 31, 2012 (2011 - $7,670). Department is not responsible for future funding of the plan deficit other than through contribution increases.

At December 31, 2011, the Management Employees Pension Plan reported a deficiency of $517,726 (2010 - $397,087), the Public Service Pension Plan reported a deficiency of $1,790,383 (2010 - $2,067,151) and the Supplementary Retirement Plan for Public Service Managers reported a deficiency of $53,489 (2010 - $39,559).

The Department also participates in two multi-employer Long Term Disability Income Continuance Plans. At March 31, 2012, the Bargaining Unit Plan reported an actuarial of surplus $9,136 (2011 - deficiency $4,141) and the Management, Opted Out and Excluded Plan an actuarial surplus of $10,454 (2011 - $7,020). The expense for these two plans is limited to the employer's annual contributions for the year.

Note 11 **Comparative Figures**

Certain 2011 figures have been reclassified to conform to the 2012 presentation.

Note 12 **Subsequent Events**

On May 8, 2012, the government announced cabinet restructuring. As a result, the Department of Seniors was disestablished and certain programs and services as prescribed by Order in Council 155/2012 were transferred to Department of Health and Wellness. The Department was renamed as "Department of Health".

Note 13 **Approval of Financial Statements**

The financial statements were approved by the Senior Financial Officer and the Deputy Minister.

Schedules to Financial Statements
Year Ended March 31, 2012

SCHEDULE 1
Revenues
(in thousands)

	2012		2011
	Budget (Schedule 4)	Actual	Actual (Restated - Note 3)
Internal Government Transfers			
Transfer from Alberta Cancer Prevention Legacy Fund	$ 25,000	$ 22,481	$ 18,750
Transfers from Government of Canada			
Canada Health Transfer	2,266,219	2,155,449	2,175,791
Wait Times Reduction	27,356	27,379	27,262
Other Health Transfers	8,113	9,036	12,061
	2,301,688	2,191,864	2,215,114
Premiums, Fees and Licenses			
Supplementary Health Benefit Premiums	57,603	56,174	57,910
Other	6	28	125
	57,609	56,202	58,035
Other Revenue			
Third Party Recoveries	95,500	96,151	94,601
Previous years' refunds of expenditure	-	62,745	49,665
Miscellaneous	654	24,983	17,370
	96,154	183,879	161,636
Total Revenue	$ 2,480,451	$ 2,454,426	$ 2,453,535

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 2

Credit or Recovery

(in thousands)

	2012		
	Authorized	Actual [a]	(Shortfall) / Excess
Support Programs			
Other Support Programs [c]	$ 1,250	$ 620	$ (630)
	$ 1,250	$ 620	$ (630) [b]

[a] Revenues from credit or recovery initiatives are included in the Department's revenues in the Statement of Operations.

[b] Shortfall is deducted from current year's authorized budget, as disclosed in Schedules 4 and 5 to the financial statements.

[c] The Department receives funding from Health Canada to enhance existing health services to persons with chronic Hepatitis C virus infection.

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 3

Expenses - Directly Incurred Detailed by Object

(in thousands)

	2012		2011
	Budget	Actual	Actual (Restated - Note 3)
Grants	$ 14,657,290	$ 14,615,017	$ 14,521,991
Supplies and Services	134,819	91,213	84,320
Salaries, Wages and Employee Benefits	78,152	76,047	71,577
Amortization of Tangible Capital Assets	17,500	15,031	13,701
Consumption of Inventories	57,291	39,613	42,525
Other	2,268	6,486	2,459
	$ 14,947,320	$ 14,843,407	$ 14,736,573

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 4

Budget

(in thousands)

	2011 - 2012 Estimates	Adjustments [a]	2011 - 2012 Budget	Authorized Supplementary	2011 - 2012 Authorized Budget
Revenues:					
Internal Government Transfers	$ 25,000	$ -	$ 25,000	$ -	$ 25,000
Transfers from Government of Canada	2,301,688	-	2,301,688	-	2,301,688
Premiums, Fees and Licences	57,609	-	57,609	-	57,609
Other Revenue	96,154	-	96,154	-	96,154
	2,480,451	-	2,480,451	-	2,480,451
Expenses - Directly Incurred:					
Programs					
Ministry Support Services [b]	57,803	-	57,803	-	57,803
Physician Compensation and Development	3,345,526	-	3,345,526	-	3,345,526
Allied Health Services	63,636	-	63,636	-	63,636
Human Tissue and Blood Services	158,902	-	158,902	-	158,902
Drugs and Supplemental Health Benefits	1,040,582	-	1,040,582	-	1,040,582
Community Programs and Healthy Living	178,118	-	178,118	-	178,118
Support Programs	250,232	-	250,232	-	250,232
Alberta Health Services	9,634,221	-	9,634,221	-	9,634,221
Health Quality Council of Alberta	4,026	-	4,026	-	4,026
Information Systems	130,174	-	130,174	-	130,174
Infrastructure Support	59,100	-	59,100	-	59,100
Cancer Research and Prevention Investment	25,000	-	25,000	-	25,000
Credit or Recovery (Shortfall) (Schedule 2)	-	(630)	(630)	-	(630)
	14,947,320	(630)	14,946,690	-	14,946,690
Net Operating Results	$ (12,466,869)	$ 630	$ (12,466,239)	-	$(12,466,239)
Capital Investment	$ 85,340	$ -	$ 85,340	$ -	$ 85,340

Note:

[a] Adjustments include encumbrances, credit or recovery increases approved by Treasury Board and credit or recovery shortfalls. Treasury Board approval is pursuant to section 24(2) of the *Financial Administration Act*.

[b] Responsibility for the administration of Cabinet Policy Committee was transferred during the year from the Department of Seniors. This resulted in an increase of $229 to the original estimates.

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 5

Comparison of Directly Incurred Expenses and Capital Investment by Element to Authorized Spending
(in thousands)

Expenses and Capital Investment	2011/2012 Estimates	Adjustments (a)	2011/2012 Budget	Authorized Supplementary	2011/2012 Authorized Budget	Amounts Not Required To Be Voted	2011/12 Authorized Spending	2011/2012 Actual	Unexpended / (Over Expended)
1 Ministry Support Services									
1.1 Minister's Office	$ 551	$ -	$ 551	$ -	$ 551	$ -	$ 551	$ 502	$ 49
1.2 Deputy Minister's Office	711	-	711	-	711	-	711	728	(17)
1.3 Communications	2,095	-	2,095	-	2,095	-	2,095	1,916	179
1.4 Strategic Corporate Support	39,390	-	39,390	-	39,390	(2)	39,388	29,788	9,600
1.5 Policy Development and Strategic Support	12,599	-	12,599	-	12,599	-	12,599	11,985	614
1.6 Health Facilities Review Committee	886	-	886	-	886	-	886	820	66
1.7 Mental Health Patient Advocate Office	871	-	871	-	871	-	871	875	(4)
1.8 Health Advocate Office	700	-	700	-	700	-	700	-	700
Sub-Total	57,803	-	57,803	-	57,803	(2)	57,801	46,614	11,187
2 Physician Compensation and Development									
2.1 Program Support	8,999	-	8,999	-	8,999	-	8,999	9,912	(913)
2.2 Physician Compensation and Support	3,078,329	-	3,078,329	-	3,078,329	-	3,078,329	3,299,632	(221,303)
2.3 Academic Alternative Relationship Plans	104,641	-	104,641	-	104,641	-	104,641	104,343	298
2.4 Medical Resident Allowances	119,829	-	119,829	-	119,829	-	119,829	89,709	30,120
2.5 Clinical Training and Assessment Support	33,728	-	33,728	-	33,728	-	33,728	33,629	99
Sub-Total	3,345,526	-	3,345,526	-	3,345,526	-	3,345,526	3,537,225	(191,699)
3 Allied Health Services	63,636	-	63,636	-	63,636	-	63,636	62,290	1,346

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 5 (continued)

Comparison of Directly Incurred Expenses and Capital Investment by Element to Authorized Spending
(in thousands)

Expenses and Capital Investment	2011/2012 Estimates	Adjustments (a)	2011/2012 Budget	Authorized Supplementary	2011/2012 Authorized Budget	Amounts Not Required To Be Voted	2011/2012 Authorized Spending	2011/2012 Actual	Unexpended / (Over Expended)
4 Human Tissue and Blood Services	$ 158,902	$ -	$ 158,902	$ -	$ 158,902	$ -	$ 158,902	$ 152,303	$ 6,599
5 Drugs and Supplemental Health Benefits									
5.1 Outpatient Cancer Therapy Drugs	119,000	-	119,000	-	119,000	-	119,000	105,331	13,669
5.2 Outpatient Specialized High Cost Drugs	75,154	-	75,154	-	75,154	-	75,154	75,154	-
5.3 Seniors Drug Benefits	595,337	-	595,337	-	595,337	-	595,337	551,396	43,941
5.4 Seniors Supplemental Health Benefits	25,694	-	25,694	-	25,694	-	25,694	27,560	(1,866)
5.5 Non-Group Drug Benefits	184,468	-	184,468	-	184,468	-	184,468	166,065	18,403
5.6 Non-Group Supplemental Health Benefits	1,737	-	1,737	-	1,737	-	1,737	1,139	598
5.7 Pharmaceutical Innovation and Management	39,192	-	39,192	-	39,192	-	39,192	30,972	8,220
Sub-Total	1,040,582	-	1,040,582	-	1,040,582	-	1,040,582	957,617	82,965
6 Community Programs and Healthy Living									
6.1 Program Support	18,363	-	18,363	-	18,363	-	18,363	16,853	1,510
6.2 Immunization Support									
- Operating Expense	63,764	-	63,764	-	63,764	(57,291)	6,473	913	5,560
- Capital Investment	55,340	-	55,340	-	55,340	-	55,340	43,993	11,347
6.3 Community-Based Health Services	53,903	-	53,903	-	53,903	-	53,903	34,250	19,653
6.4 Safe Communities	42,088	-	42,088	-	42,088	-	42,088	28,030	14,058
Sub-Total	233,458	-	233,458	-	233,458	(57,291)	176,167	124,039	52,128

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 5 (continued)

Comparison of Directly Incurred Expenses and Capital Investment by Element to Authorized Spending

(in thousands)

Expenses and Capital Investment	2011/2012 Estimates	Adjustments (a)	2011/2012 Budget	Authorized Supplementary	2011/2012 Authorized Budget	Amounts Not Required To Be Voted	2011/2012 Authorized Spending	2011/2012 Actual	Unexpended / (Over Expended)
7 Support Programs									
7.1 Program Support	$ 10,984	$ -	$ 10,984	$ -	$ 10,984	$ -	$ 10,984	$ 10,159	$ 825
7.2 Out-of-Province Health Care Services	123,735	-	123,735	-	123,735	-	123,735	111,902	11,833
7.3 Health Services Research	3,535	-	3,535	-	3,535	-	3,535	3,535	-
7.4 Continuing Care Initiatives	24,000	-	24,000	-	24,000	-	24,000	3,504	20,496
7.5 Health Services provided in Correctional Facilities	25,180	-	25,180	-	25,180	-	25,180	17,137	8,043
7.6 Other Support Programs	62,798	-	62,798	-	62,798	(2,000)	60,798	8,999	51,799
Sub-Total	250,232	-	250,232	-	250,232	(2,000)	248,232	155,236	92,996
8 Alberta Health Services									
8.1 Acute Care Services	3,694,000	-	3,694,000	-	3,694,000	-	3,694,000	3,694,000	-
8.2 Facility and Home-Based Continuing Care Services	1,076,000	-	1,076,000	-	1,076,000	-	1,076,000	1,076,000	-
8.3 Community and Population Health Services	912,000	-	912,000	-	912,000	-	912,000	912,000	-
8.4 Diagnostic and Therapeutic Services	1,657,000	-	1,657,000	-	1,657,000	-	1,657,000	1,657,000	-
8.5 Support Services	2,295,221	-	2,295,221	-	2,295,221	-	2,295,221	2,295,221	-
Sub-Total	9,634,221	-	9,634,221	-	9,634,221	-	9,634,221	9,634,221	-
9 Health Quality Council of Alberta	4,026	-	4,026	-	4,026	-	4,026	4,026	-

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 5 (continued)

Comparison of Directly Incurred Expenses and Capital Investment by Element to Authorized Spending
(in thousands)

Expenses and Capital Investment	2011/2012 Estimates	Adjustments [a]	2011/2012 Budget	Authorized Supplementary	2011/2012 Authorized Budget	Amounts Not Required To Be Voted	2011/2012 Authorized Spending	2011/2012 Actual	Unexpended / (Over Expended)
10 Information Systems									
10.1 Program Support	$ 24,572	$ -	$ 24,572	$ -	$ 24,572	$ -	$ 24,572	$ 19,668	$ 4,904
10.2 Information Systems									
- Operating Expense	105,602	-	105,602	-	105,602	(17,500)	88,102	70,185	17,917
- Capital Investment	30,000	-	30,000	-	30,000	-	30,000	15,681	14,319
Sub-Total	160,174	-	160,174	-	160,174	(17,500)	142,674	105,534	37,140
11 Infrastructure Support									
11.1 Facilities Planning	4,100	-	4,100	-	4,100	-	4,100	85	4,015
11.2 Cancer Corridor Projects	10,000	-	10,000	-	10,000	-	10,000	175	9,825
11.3 External Information Systems	20,000	-	20,000	-	20,000	-	20,000	15,607	4,393
11.4 Medical Equipment Replacement and Upgrade Program	25,000	-	25,000	-	25,000	-	25,000	25,000	-
Sub-Total	59,100	-	59,100	-	59,100	-	59,100	40,867	18,233
Cancer Research and Prevention Investment	25,000	-	25,000	-	25,000	(2,519)	22,481	22,481	-
Credit or Recovery (Shortfall) (Schedule 2)	-	(630)	(630)	-	(630)	-	(630)	-	(630)
Total	15,032,660	(630)	15,032,030	-	15,032,030	(79,312)	14,952,718	14,842,453	110,265
Operating Expense	14,947,320	(630)	14,946,690	-	14,946,690	(79,312)	14,867,378	14,782,779	84,599
Capital Investment	85,340	-	85,340	-	85,340	-	85,340	59,674	25,666
Total Expenses and Capital Investment	$ 15,032,660	$ (630)	$ 15,032,030	$ -	$ 15,032,030	$ (79,312)	$ 14,952,718	$ 14,842,453	$ 110,265

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[a] Adjustments include encumbrances, credit or recovery increases approved by Treasury Board and credit or recovery shortfalls. Treasury Board approval is pursuant to section 24(2) of the Financial Administration Act.

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 6

Lottery Fund Estimates

(in thousands)

	2011/2012 Lottery Fund Estimates	2011/2012 Actual	Unexpended (Over Expended)
Alberta Health Services			
- Community and Population Health Services	$ 450,000	$ 450,000	$ -
	$ 450,000	$ 450,000	$ -

The revenue of the Lottery Fund is transferred to the Department of Finance on behalf of the General Revenue Fund. Having been transferred to the General Revenue Fund, these monies then become part of the Department's supply vote. This table shows details of the initiatives within the department that are funded by the Lottery Fund and compares it to the actual results.

Schedules to Financial Statements
Year Ended March 31, 2012

SCHEDULE 7
Salary and Benefits Disclosure
(in dollars)

	2012				2011
	Base Salary [1]	Other Cash Benefits [2]	Other Non-cash Benefits [3]	Total	Total
Deputy Minister [4] [5]	$ 279,538	$ 1,250	$ 83,304	$ 364,092	$ 360,793
Executives - Assistant Deputy Ministers					
Health Information Technology and Systems	162,646	1,250	44,204	208,100	197,692
Community and Population Health	175,982	1,250	48,512	225,744	213,750
Health Workforce	185,472	15,462	51,378	252,312	231,803
Health Policy and Service Standards	185,472	1,250	50,518	237,240	238,405
Financial Accountability	213,293	1,250	60,378	274,921	266,310
Corporate Support	185,472	1,250	53,072	239,794	233,083
Policy & Issues Coordination [6]	47,122	1,250	14,593	62,965	-
Executives - Other					
Executive Director, Human Resources	151,836	1,250	42,082	195,168	191,108

Prepared in accordance with Treasury Board Directive 12/98 as amended

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include vacation payouts and lump sum payments. There were no bonuses paid in 2012.

(3) Other non-cash benefits include government's share of all employee benefits and contributions or payments made on behalf of employees including pension and supplementary retirement plan, health care, dental coverage, group life insurance, short and long-term disability plans, professional memberships and tuition fees.

(4) Automobile provided, no dollar amount is included in other non-cash benefits.

(5) The position was occupied by two individuals during the year. The previous incumbent was Deputy Minister until October 12, 2011.

(6) The position was created on December 19, 2011.

Schedules to Financial Statements
Year Ended March 31, 2012

SCHEDULE 8
Related Party Transactions
(in thousands)

Related parties are those entities consolidated or accounted for on the modified equity basis in the Government of Alberta's financial statements. Related parties also include management in the department. Entities in the Ministry include Alberta Health Services and its controlled entities and the Health Quality Council of Alberta.

The Department and its employees paid or collected certain taxes and fees set by regulation for permits, licences and other charges. These amounts were incurred in the normal course of business, reflect charges applicable to all users, and have been excluded from this schedule.

The Department had the following transactions with related parties recorded on the Statement of Operations and the Statement of Financial Position at the amounts of consideration agreed upon between the related parties.

	Entities in the Ministry		Other Entities	
	2012	2011	2012	2011 (Restated - Note 3)
Revenues				
Grants	$ -	$ -	$ 22,481	$ 18,750
Other	30,423	22,412	-	2,664
	$ 30,423	$ 22,412	$ 22,481	$ 21,414
Expenses - Directly Incurred				
Grants	$ 10,182,036	$ 10,252,646	$ 96,633	$ 183,291
Other Services	-	-	6,851	7,732
	$ 10,182,036	$ 10,252,646	$ 103,484	$ 191,023
Receivable from	$ 17,392	$ 14,425	$ -	$ 1,000
Payable to	$ 79,302	$ 203,837	$ 1,080	$ 6,074
Contractual Obligations	$ 187,408	$ 289,868	$ 29,576	$ 45,571

The Department also had the following transactions with related parties for which no consideration was exchanged. The amounts for these related party transactions are estimated based on the costs incurred by the service provider to provide the service. These amounts are not recorded in the financial statements but are disclosed in Schedule 9.

	Entities in the Ministry		Other Entities	
	2012	2011	2012	2011
Expenses - Incurred by Others				
Accommodation	$ -	$ -	$ 10,802	$ 9,834
Legal	-	-	3,224	2,678
Other	-	-	8,415	8,097
	$ -	$ -	$ 22,441	$ 20,609

Schedules to Financial Statements

Year Ended March 31, 2012

SCHEDULE 9

Allocated Costs

(in thousands)

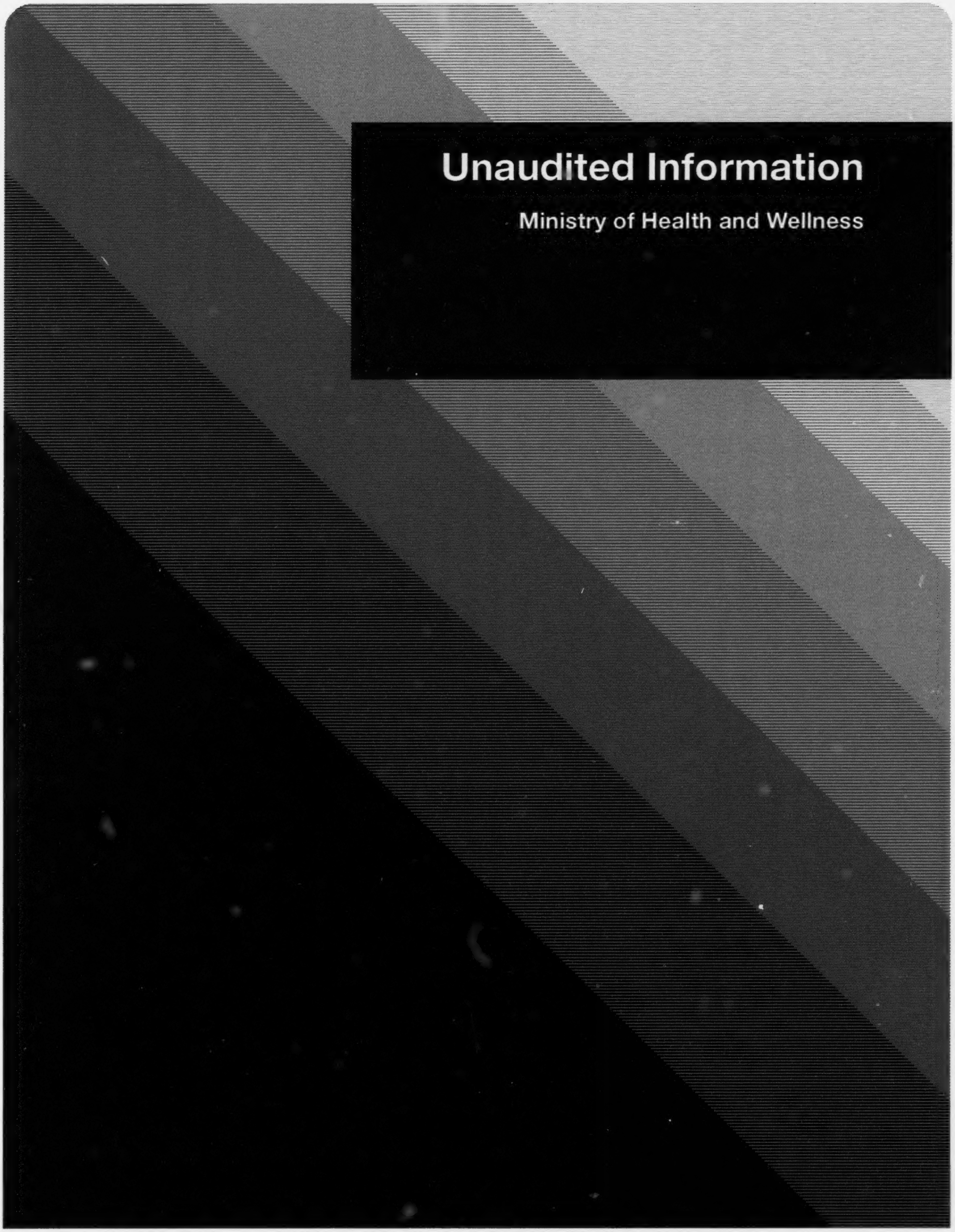
	2012					2011
		Expenses - Incurred by Others				(Restated - Note 3)
	Expenses (1)	Accommodation Costs (2)	Legal Services (3)	Other Costs (4)	Total	Total
Ministry Support Services	$ 46,568	$ 10,802	$ 3,224	$ 8,415	$ 69,009	$ 65,946
Physician Compensation and Development	3,537,233	-	-	-	3,537,233	3,285,046
Allied Health Services	62,290	-	-	-	62,290	55,666
Human Tissue and Blood Services	152,303	-	-	-	152,303	160,239
Drugs and Supplemental Health Benefits	957,617	-	-	-	957,617	942,081
Community Programs and Healthy Living	122,541	-	-	-	122,541	119,550
Support Programs	158,594	-	-	-	158,594	317,995
Alberta Health Services	9,634,221	-	-	-	9,634,221	9,615,150
Health Quality Council of Alberta	4,026	-	-	-	4,026	3,623
Information Systems	104,666	-	-	-	104,666	102,015
Infrastructure Support	40,867	-	-	-	40,867	71,121
Cancer Research and Prevention Investment	22,481	-	-	-	22,481	18,750
	$ 14,843,407	$ 10,802	$ 3,224	$ 8,415	$ 14,865,848	$ 14,757,182

(1) Expenses - Directly Incurred as per Statement of Operations.

(2) Costs shown for Accommodation (includes grants in lieu of taxes) on Schedule 8.

(3) Costs shown for Legal Services on Schedule 8.

(4) Other Costs includes services the Department receives under contracts managed by Service Alberta shown on Schedule 8.



Unaudited Information

Ministry of Health and Wellness

Unaudited Information

STATEMENT OF REMISSIONS, COMPROMISES AND WRITE-OFFS

FOR THE YEAR ENDED MARCH 31, 2012

(UNAUDITED)
(in thousands)

		2012	**2011**
Compromises			
	Health Care Insurance Premiums	$ 45	$ 52
Write-offs			
	Health Care Insurance Premiums	2,111	8,187
	Medical Claim Recoveries	2,260	2,051
	Penalties, Interest and Miscellaneous Charges	146	429
Total Remissions, Compromises and Write-offs		$ 4,562	$ 10,719

Health Authority Financial Statement Highlights

This section highlights the financial results of Alberta Health Services (AHS) and the Health Quality Council of Alberta (HQCA) for the fiscal year ended March 31, 2012. The financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles (GAAP) and Alberta Health and Wellness' Financial Directives. Effective April 1, 2012, AHS and HQCA will report under Public Sector Accounting (PSA) Standards.

ALBERTA HEALTH SERVICES

Operating Results

- For fiscal 2011 – 2012 AHS reported an $85 million operating surplus, compared to a prior year surplus of $856 million.
- 2011 – 2012 expenditures were $11.7 billion, compared to $10.8 billion in the prior year — an 8.7 per cent increase overall, of which 4.5 per cent or $489 million related to salaries and benefits. AHS employed 66,532 Full-Time-Equivalents as of March 31, 2012.
- Administration costs in 2011/2012 were $364 million, or 3.1 per cent of total expenditures. This compares to administration costs in 2010 – 2011 of $304 million, or 2.8 per cent of total expenditures.

Financial Position

- At March 31, 2012, AHS reported an accumulated surplus of $82 million after internally restricting $45 million to fund start up costs at Calgary's South Health Campus Hospital and $25 million to establish a parking infrastructure reserve for future maintenance, upgrades and construction.
- AHS reported net assets and endowments of $1 billion at March 31, 2012, a $99 million increase from the prior year.
- At March 31, 2012, AHS reported long-term debt of $370 million, an increase of $34 million from the prior year, the majority of which relates to the construction of parkades. AHS is compliant with its authorized borrowing limits.
- AHS reported capital assets of $7.2 billion at March 31, 2012, up from $6.7 billion in the prior year.

HEALTH QUALITY COUNCIL OF ALBERTA

Operating Results

- For fiscal 2011 – 2012 HQCA reported an operating deficit of $430 thousand, compared to a prior year surplus of $239 thousand. The decreased surplus reflects HQCA's commitment to achieving the goals outlined in its 2011 – 2012 business plan. These goals include patient safety reviews, surveys, and measuring and monitoring activities.
- 2011 – 2012 expenditures were $5.6 million, compared to $4.4 million in the prior year — a 27 per cent increase overall, including a 9.7 per cent increase related to salaries and benefits. HQCA employed 19 Full-Time-Equivalents as of March 31, 2012.

Financial Position

- At March 31, 2012, HQCA reported an accumulated surplus of $226 thousand compared to an accumulated surplus of $824 thousand in the prior year.
- HQCA reported net assets of $455 thousand at March 31, 2012, a decrease of $430 thousand from the prior year, reflecting HQCA's commitment to achieving its business plan goals.
- HQCA reported capital assets of $229 thousand at March 31, 2012, compared to $61 thousand in the prior year.
- HQCA has no long-term debt.

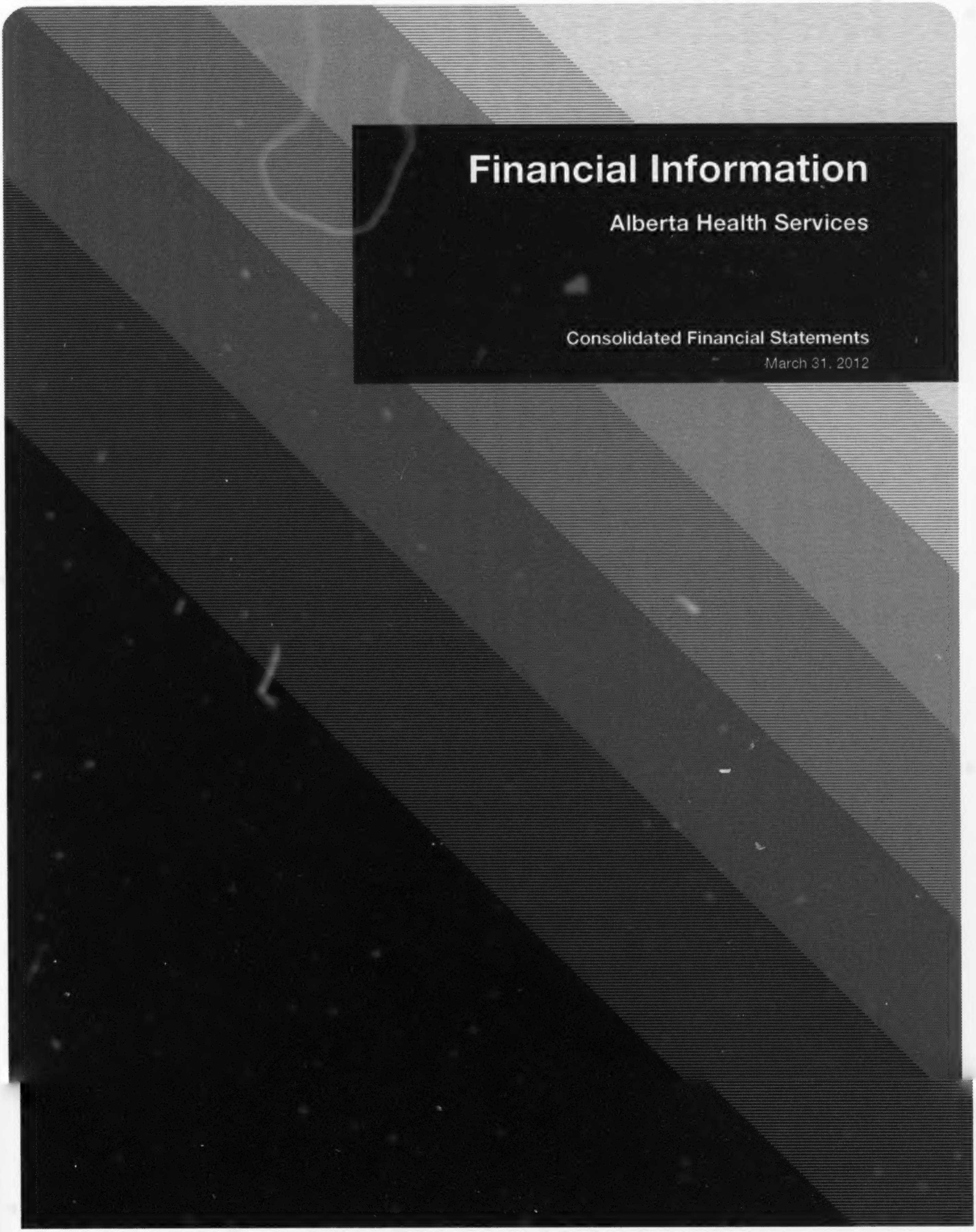
Other

- With the proclamation of the *Health Quality Council of Alberta Act* on February 1, 2012, this is the last year that HQCA will report as a health authority. Effective April 1, 2012, HQCA's reporting will be guided by the requirements of the new Act.

TABLE I

HEALTH AUTHORITY
SUMMARY OF OTHER FINANCIAL INFORMATION
FOR THE YEAR ENDED MARCH 31, 2012
(In Thousands)

	ALBERTA HEALTH SERVICES		HEALTH QUALITY COUNCIL OF ALBERTA	
	2011/2012 ACTUAL	2010/2011 ACTUAL	2011/2012 ACTUAL	2010/2011 ACTUAL
I. OPERATING SURPLUS/(DEFICIT) AS A % OF TOTAL REVENUE	0.7%	7.4%	-8.4%	5.1%
II. ADMINISTRATION COST AS A % OF TOTAL EXPENSES	3.1%	2.8%	96.3%	97.7%
III. WORKING CAPITAL				
Current Assets	2,248,593	2,281,114	977	2,506
Current Liabilities	2,115,569	2,283,882	751	1,682
WORKING CAPITAL RATIO	1.06	1.00	1.30	1.49
IV. ALBERTA HEALTH AND WELLNESS FUNDING COVERAGE	89.5%	95.8%	89.7%	104.5%
V. AVERAGE REMAINING USEFUL LIFE OF CAPITAL EQUIPMENT IN YEARS *(includes information systems)*	3.5	3.0	4.7	1.7
VI. CAPITAL INVESTMENTS DURING THE YEAR				
Funded from Internal Resources				
Equipment	137,402	107,612	217	63
Information Systems	88,337	137,082	-	-
Facilities and Improvements	5,695	-	-	-
	231,434	244,694	217	63
Funded by External Parties				
Equipment	67,988	94,365	-	-
Information Systems	49,907	43,331	-	-
Facilities and Improvements	105,667	467,154	-	-
	223,562	604,850	-	-
Total capital investments during the year *(excludes debt-funded and donated assets)*	454,996	849,544	217	63
VII. TOTAL FTEs *(excludes Board)*	66,532	64,618	19	17



Financial Information

Alberta Health Services

Consolidated Financial Statements

March 31, 2012

Alberta Health Services

CONSOLIDATED FINANCIAL STATEMENTS

MARCH 31, 2012

Alberta Health Services

Management's Responsibility for Financial Reporting

Independent Auditor's Report

Consolidated Statement of Operations

Consolidated Statement of Financial Position

Consolidated Statement of Changes in Net Assets

Consolidated Statement of Cash Flows

Notes to the Consolidated Financial Statements

Schedule 1 – Consolidated Schedule of Expenses by Object

Schedule 2 – Consolidated Schedule of Salaries and Benefits

Schedule 3 – Consolidated Schedule of Budget

Schedule 4 – Consolidated Schedule of Restatements

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2012

The accompanying consolidated financial statements for the year ended March 31, 2012 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles and the financial directives issued by Alberta Health and Wellness, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit and Finance Committee. This Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original signed by]

Dr. Chris Eagle
President and Chief Executive Officer
Alberta Health Services

[Original signed by]

Deborah Rhodes, C.A.
Senior Vice President Finance
Alberta Health Services

[Original signed by]

Allaudin Merali, C.A.
Executive Vice President and Chief Financial Officer
Alberta Health Services

June 7, 2012

AUDITOR
GENERAL
Alberta

Independent Auditor's Report

To the Members of the Alberta Health Services Board and the Minister of Health

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2012 and the consolidated statements of operations, changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2012 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 7, 2012

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS FOR THE YEAR ENDED MARCH 31, 2012

	2012		2011
	Budget (Note 4) (Schedule 3)	Actual	Actual Restated (Note 3) (Schedule 4)
Revenue:			
Alberta Health and Wellness contributions			
Unrestricted ongoing	$ 9,634,000	$ 9,634,221	$ 9,036,852
Unrestricted deficit funding (Note 5)	-	-	527,235
Restricted	818,000	835,412	747,830
Other government contributions	113,000	141,391	101,805
Fees and charges	452,000	416,385	427,058
Ancillary operations	117,000	124,213	112,367
Donations	30,000	39,535	28,574
Investment and other income (Note 6)	237,000	248,299	275,209
Amortized external capital contributions (Note 15)	370,000	342,305	364,181
TOTAL REVENUE	11,771,000	11,781,761	11,621,111
Expenses:			
Inpatient acute nursing services	2,729,000	2,812,157	2,567,686
Emergency and other outpatient services	1,274,000	1,279,016	1,216,408
Facility-based continuing care services	914,000	893,482	829,568
Ambulance services	379,000	391,674	352,407
Community-based care	983,000	920,594	797,765
Home care	437,000	428,814	402,148
Diagnostic and therapeutic services	2,011,000	1,930,120	1,855,524
Promotion, prevention and protection services	344,000	310,914	289,313
Research and education	206,000	198,035	207,023
Administration (Note 7)	392,000	363,921	304,225
Information technology	429,000	434,442	387,648
Support services	1,474,000	1,528,142	1,357,003
Amortization of facilities and improvements	219,000	205,859	198,238
TOTAL EXPENSES (Schedule 1)	11,791,000	11,697,170	10,764,956
Operating surplus (deficiency) of revenue over expenses	$ (20,000)	$ 84,591	$ 856,155

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2012

	2012 Actual	2011 Actual Restated (Note 3) (Schedule 4)
ASSETS		
Current:		
Cash and cash equivalents (Note 9)	$ 558,700	$ 764,143
Investments (Note 9)	1,217,043	957,322
Accounts receivable	238,757	201,293
Contributions receivable from Alberta Health and Wellness	78,253	200,313
Inventories	96,740	99,097
Prepaid expenses	59,100	58,946
	2,248,593	2,281,114
Non-current cash and investments (Note 9)	376,505	599,335
Capital contributions receivable from Alberta Health and Wellness	2,293	11,476
Capital assets (Note 10)	7,215,171	6,707,464
Other assets (Note 11)	129,493	96,104
TOTAL ASSETS	$ 9,972,055	$ 9,695,493
LIABILITIES AND NET ASSETS		
Current:		
Accounts payable and accrued liabilities	$ 1,198,261	$ 1,136,937
Accrued vacation pay	428,146	385,525
Deferred contributions (Note 12)	450,360	607,621
Current portion of long-term debt (Note 14)	38,802	153,799
	2,115,569	2,283,882
Deferred capital contributions (Note 13)	359,918	541,856
Long-term debt (Note 14)	331,177	182,500
Unamortized external capital contributions (Note 15)	5,974,714	5,598,973
Other liabilities (Note 16)	147,719	144,540
	8,929,097	8,751,751
Net assets:		
Accumulated surplus	81,982	98,909
Accumulated net unrealized gains (losses) on investments	4,916	(9,110)
Other internally restricted net assets (Note 17)	69,538	66,722
Internally restricted net assets invested in capital assets	876,372	777,071
Endowments (Note 18)	10,150	10,150
	1,042,958	943,742
TOTAL LIABILITIES AND NET ASSETS	$ 9,972,055	$ 9,695,493

Commitments and contingencies (Note 20)

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS FOR THE YEAR ENDED MARCH 31, 2012

	2012						2011
	Accumulated surplus (deficit)	Accumulated net unrealized gains/ (losses) on investments	Other internally restricted net assets (Note 17)	Internally restricted net assets invested in capital assets	Endowments (Note 18)	Total	Total Restated (Note 3)
Balance at beginning of year (restated)	$ 98,909	$ (9,110)	$ 66,722	$ 777,071	$ 10,150	$ 943,742	$ 111,440
Operating surplus (deficiency) of revenue over expenses	84,591	-	-	-	-	84,591	856,155
Capital assets purchased with internal funds	(219,655)	-	-	219,655	-	-	-
Land purchased with external funds	-	-	-	599	-	599	2,500
Amortization of internally funded capital assets	132,059	-	-	(132,059)	-	-	-
Repayment of long-term debt used to fund capital assets	(10,655)	-	-	10,655	-	-	-
Net repayment of life lease deposits	(451)	-	-	451	-	-	-
Transfer of other internally restricted net assets	(2,816)	-	2,816	-	-	-	-
Net unrealized gains (losses) arising during the period on available for sale financial assets	-	22,781	-	-	-	22,781	(5,074)
Transfer of net realized losses (gains) on investments to revenue	-	(8,755)	-	-	-	(8,755)	(21,279)
Balance at end of year	$ 81,982	$ 4,916	$ 69,538	$ 876,372	$ 10,150	$ 1,042,958	$ 943,742

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2012

	2012		2011
	Budget (Note 4)	Actual	Actual Restated (Note 3) (Schedule 4)
Operating activities:			
Operating surplus (deficiency) of revenue over expenses	$ (20,000)	$ 84,591	$ 856,155
Non-cash transactions:			
Amortization expense (Schedule 1)	495,000	474,513	470,511
Amortized external capital contributions	(370,000)	(342,550)	(364,606)
Other	16,000	(14,947)	47,505
Changes in non-cash working capital (Note 19)	(53,000)	(245,106)	(737,874)
Cash generated from (used by) operating activities	68,000	(43,499)	271,691
Investing activities:			
Purchase of capital assets:			
Internally funded equipment	(65,000)	(137,402)	(107,612)
Internally funded information systems	(135,000)	(88,337)	(137,082)
Internally funded facilities and improvements	-	(5,695)	-
Externally funded equipment	(220,000)	(67,988)	(94,365)
Externally funded information systems	(70,000)	(49,907)	(43,331)
Externally funded facilities and improvements	(60,000)	(105,667)	(467,154)
Debt funded facilities and improvements	(62,000)	(31,921)	(71,353)
Purchase of investments	(5,365,000)	(5,099,643)	(7,343,537)
Proceeds on sale of investments	5,229,000	5,297,831	5,995,607
Allocations from non-current cash and investments	658,000	38,668	1,721,856
Changes in non-cash working capital (Note 19)	378,000	18,868	76,458
Cash generated from (used by) investing activities	288,000	(231,193)	(470,513)
Financing activities:			
Capital contributions received	107,000	171,082	202,923
Capital contributions returned	-	(15,759)	(58,850)
Capital contributions payable transferred to accounts payable	-	(119,754)	-
Proceeds from long-term debt	240,000	194,000	73,160
Principal payments on long-term debt	(209,000)	(160,320)	(12,565)
Cash generated from financing activities	138,000	69,249	204,668
Net increase (decrease) in current cash and cash equivalents	494,000	(205,443)	5,846
Current cash and cash equivalents, beginning of year	1,721,000	764,143	758,297
Current cash and cash equivalents, end of year	$ 2,215,000	$ 558,700	$ 764,143

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2012

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta). Effective April 1, 2009, the name of East Central Health was amended to Alberta Health Services. All other Regional Health Authorities, the Alberta Mental Health Board, the Alberta Cancer Board and the Alberta Alcohol and Drug Abuse Commission were disestablished and amalgamated with AHS. All assets, liabilities, rights and obligations of the disestablished entities were assumed by AHS.

Pursuant to the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the population;
- determine priorities in the provision of health services and allocate resources accordingly;
- ensure reasonable access to quality health services; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities.

Additionally, the Mandate and Roles Document, developed by both Alberta Health and Wellness (AHW) and AHS to define the roles, responsibilities and accountabilities of each entity, identifies that AHS is accountable to the Minister of Health and Wellness (the Minister) for the delivery and operation of the public health system while AHW is mandated to support the Minister by providing direction to AHS, and in establishing AHS performance measures and targets and measuring AHS's performance.

The AHS consolidated financial statements include the revenues and expenses associated with AHS responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For example the Department of Health and Wellness is responsible for paying most physician fees. The Ministry of Health and Wellness consolidated financial statements contain a more complete view of the cost of the provincial health care system. For a complete picture of the costs of provincial healthcare readers should consult the Province of Alberta consolidated financial statements.

AHS's operations include the facilities and sites listed in the AHS annual report. AHS is a registered charity under the *Income Tax Act* (Canada) and is exempt from the payment of income tax.

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

The consolidated financial statements have been prepared in accordance with Canadian Generally Accepted Accounting Principles and the reporting requirements of AHW in Financial Directive 5.

(i) These financial statements have been prepared on a consolidated basis. Included in these consolidated financial statements are the following wholly owned subsidiaries:

- Calgary Laboratory Services Ltd. (CLS), who provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. (CCGI), who manages continuing care programs and facilities in the Edmonton area.
- Carewest, who manages continuing care programs and facilities in the Calgary area.

The transactions between AHS and these subsidiaries have been eliminated on consolidation. These entities of AHS are exempt from the payment of income tax.

(ii) AHS uses the proportionate consolidation method to account for its 50% interest in the Northern Alberta Clinical Trials Centre joint venture with the University of Alberta, and its 50% interest in the Primary Care Networks disclosed in Note 21(b).

(iii) AHS consolidates its interest in the Provincial Health Authorities of Alberta Liability and Property Insurance Plan (the LPIP). AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber. The LPIP is exempt from the payment of income tax but is subject to the Alberta provincial premium tax.

(iv) These consolidated financial statements do not include the assets, liabilities and operations of controlled foundations (Note 21(c)), voluntary or private contracted health service providers in the Province (Note 21(d)), or the Health Benefit Trust of Alberta (Note 21(e)). These consolidated financial statements do not include trust funds administered on behalf of others (Note 22).

(b) Revenue Recognition

These consolidated financial statements have been prepared using the deferral method of accounting for contributions; the key elements of AHS's revenue recognition policies are:

(i) Unrestricted contributions are recognized as revenue in the year received or receivable if the amount to be received is reasonably estimated and collection is reasonable assured.

(ii) Externally restricted non-capital contributions are deferred and recognized as revenue in the year the related expenses are incurred.

(iii) Externally restricted capital contributions are recorded as deferred capital contributions until invested in capital assets. Amounts expended, representing externally funded capital assets, are then transferred to unamortized external capital contributions. Unamortized external capital contributions are recognized as revenue in the year the related amortization expense of the funded capital asset is recorded.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(iv) Contributions receivable from AHW and capital contributions receivable from AHW are recorded as receivable when the grant agreement has been fully executed.

(v) Pledges receivable from foundations are recorded as receivable when amounts to be received can be reasonably estimated and ultimate collection is reasonably assured.

(vi) Externally restricted contributions to purchase capital assets that will not be amortized and endowments are treated as direct increases to net assets.

(vii) Investment income includes dividend and interest income, and realized gains or losses on the sale of investments. Unrealized gains and losses on available for sale investments are included directly in net assets or deferred contributions as appropriate, until the related investments are sold. Unrealized gains and losses on held for trading investments are included in the Consolidated Statement of Operations. Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Other unrestricted investment income is recognized as revenue when earned.

(viii) In kind contributions of services and materials are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS the value of their services are not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(ix) Revenue from sales of goods and services is recorded in the period that goods are delivered or services are provided, and are presented net of bad debt expense.

(c) Cash, Cash Equivalents and Investments

Cash and cash equivalents consist of cash on hand, balances with banks and investments in money market securities with maturities of less than three months.

Current investments consist of money market securities with original maturities of greater than three months and fixed income securities to be used in funding AHS's operations in the upcoming fiscal year.

Cash, cash equivalents and current investments are comprised of both unrestricted and restricted funds. Unrestricted funds are used for general operating purposes or internally funded capital projects.

Restricted funds consist of received but unspent deferred contributions, deferred capital contributions, amounts restricted to fund long-term insurance obligations (Note 9(d)) and other liabilities.

Non-current cash and investments consist of cash and investments in fixed income securities and equities. All non-current investments are restricted and are mainly comprised of received but unspent non-current deferred contributions and deferred capital contributions.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Investments are accounted for in accordance with the accounting policies described in Note 2(e). Transaction costs associated with the acquisition and disposal of available for sale investments are capitalized and are included in the acquisition costs or reduce proceeds on disposal. Investment management fees are expensed as incurred. The purchase and sale of investments are accounted for using trade-date accounting.

(d) Inventories

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and current replacement value. All other inventories are valued at lower of cost (defined as moving average cost) and net realizable value.

(e) Financial Instruments

AHS has classified its financial assets and financial liabilities as follows:

Financial Assets and Liabilities	Classification	Subsequent Measurement and Recognition
Cash and cash equivalents	Held for trading	Measured at fair value with changes in fair value recognized in the Consolidated Statement of Operations.
Investments	Available for sale	Measured at fair value with changes in fair value recognized in the Consolidated Statement of Changes in Net Assets or deferred contributions until realized, at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
	Held for trading	Measured at fair value with changes in fair value recognized in the Consolidated Statement of Operations.
Accounts receivable, contributions and capital contributions receivable from AHW	Loans and receivables	After initial fair value measurement, measured at amortized cost using the effective interest rate method.
Accounts payable and accrued liabilities, long-term debt, provision for unpaid claims and life lease deposits	Other financial liabilities	After initial fair value measurement, measured at amortized cost using the effective interest rate method.

AHS does not use hedge accounting and is not impacted by the requirements of Canadian Institute of Chartered Accountants (CICA) accounting standard Section 3865 - Hedges. AHS, as a not-for-profit organization, elected to not apply the standards for embedded derivatives in non-financial contracts. In addition, AHS has elected not to adopt Section 3862 Financial Instruments - Disclosures and Section 3863 Financial Instruments - Presentation, and instead has continued to disclose financial instruments under Section 3861 – Financial Instruments Disclosure and Presentation.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

When it is determined that an impairment of a financial instrument classified as available for sale is other than temporary, the cumulative loss that had been recognized directly in net assets or deferred contributions is removed and recognized in the Consolidated Statement of Operations even though the financial asset has not been derecognized. Impairment losses recognized in the Consolidated Statement of Operations for a financial instrument classified as available for sale are not reversed.

The carrying value of current cash and cash equivalents, accounts receivable, contributions and capital contributions receivable from AHW, accounts payable and accrued liabilities approximate their fair value because of the short term nature of these items. Unless otherwise noted, it is management's opinion that AHS is not exposed to significant interest, currency or credit risks arising from its financial instruments.

Additional disclosure on financial instruments is provided in Note 9 Cash, Cash Equivalents and Investments, Note 14 Long-term Debt and Note 16 Other Liabilities.

(f) Capital Assets

Capital assets and work in progress are recorded at cost. Capital assets and work in progress acquired from other Alberta government organizations are recorded at the carrying value of that government organization. Costs incurred by Alberta Infrastructure (AI) to build capital assets on behalf of AHS are recorded by AHS as work in progress and unamortized external capital contributions as AI incurs costs. Contributed capital assets from non-Alberta government organizations are recorded at fair value at the date of contribution.

The threshold for capitalizing new systems development is $250 and major enhancements is $100. The threshold for all other capital assets is $5. All land is capitalized.

Capital assets are amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	2-20 years
Information systems	3-5 years
Building service equipment	5-40 years
Leased facilities and improvements	term of lease
Land improvements	5-40 years

Work in progress, which includes facilities and improvements projects and development of information systems, is not amortized until after a project is complete. Leases transferring substantially all benefits and risks of capital asset ownership are reported as capital asset acquisitions financed by long-term obligations.

(g) Asset Retirement Obligations

AHS recognizes the fair value of a future asset retirement obligation as a liability in the period in which it incurs a legal obligation associated with the retirement of tangible long-lived assets that results from the acquisition, construction, development, and/or normal use of the respective assets. AHS concurrently recognizes a corresponding increase in the carrying amount of the related long-lived asset that is amortized over the life of the asset. The fair value of the asset retirement obligation is estimated using the expected cash flow approach that reflects a range of possible outcomes discounted at a credit-adjusted risk-free interest rate.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Subsequent to the initial measurement, the asset retirement obligation is adjusted at the end of each period to reflect the passage of time and changes in the estimated future cash flows underlying the obligation. Changes in the obligation due to the passage of time are recognized as an operating expense using the effective interest method. Changes in the obligation due to changes in estimated cash flows are recognized as an adjustment of the carrying amount of the related long-lived asset that is amortized over the remaining life of the asset.

An asset retirement obligation related to the removal of hazardous material that would be required as part of a capital project is only recognized when there is approval from the Minister of Health and Wellness to proceed with the project.

(h) Employee Future Benefits

Registered Defined Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants, based on years of service and final average earnings. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The Minister of Finance is the legal trustee and administrator of the plans. The Department of Finance accounts for the liabilities for pension obligations as a participating employer for former and current employees in the LAPP and the MEPP for all of the organizations included in the Government of Alberta (GOA) consolidated reporting entity except for government business enterprises. As AHS is included in the GOA consolidated reporting entity AHS follows the standards for defined contribution accounting for these pension plans. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year.

Supplemental Executive Retirement Plans (SERPs)

AHS sponsors three defined benefit SERPs which are funded. These plans cover certain employees and supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). Each plan was closed to new entrants effective April 1, 2009. A majority of the SERPs are final average plans; however, certain participant groups have their benefits determined on a career average basis. Also, some participant groups receive post-retirement indexing similar to the benefits provided under the registered defined benefit pension plans; while others receive non-indexed benefits. The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service and management's best estimate assumptions, including a market-related discount rate.

Due to *Income Tax Act* (Canada) requirements, the SERPs are subject to the Retirement Compensation Arrangement (RCA) rules; therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERPs are invested in a fixed income portfolio. The net benefit cost of SERPs reported in these consolidated financial statements include the current service cost, interest cost on the current service cost and obligations, as well as the amortization of past service cost, initial obligations and net actuarial gains and losses. These amounts are offset by the expected return on the plans' assets.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Past service costs, including the initial obligations of the plans, are amortized on a straight-line basis over the average remaining service lifetime of the relevant employee group. Cumulative net actuarial gains or losses over 10 percent of the greater of the benefit obligation and fair value of the plans' assets are amortized on a straight-line basis over the average remaining service lifetime of the employee group. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net benefit cost in the following year.

In the case of a curtailment event which results in the elimination for a significant number of active employees of the right to earn defined benefits for their future services, a curtailment gain or loss is recorded. A curtailment loss is recognized in income when it is probable that a curtailment will occur and the net effects are reasonably estimable. A curtailment gain is recognized in income when the event giving rise to a curtailment has occurred.

Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff who would have been eligible for SERP, are enrolled in a defined contribution SPP. Similar to the SERP, the SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, excluding pay at risk, in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short term disability, long term disability, extended health, dental and vision benefits through benefits carriers. AHS's contributions are expensed to the extent that they do not relate to discretionary reserves. AHS also provides its employees with sick leave benefits. AHS records non-vesting sick leave as an expense when the benefit is taken by the employee.

(i) Long-term Care Partnerships

Funding paid or payable related to long-term care partnership agreements is recognized as an expense in the period the transfer is authorized and all eligibility criteria have been met by the providers. AHS recognizes the expense in facility-based continuing care services on the Consolidated Statement of Operations and, if externally funded, an equal amount of revenue as other government contributions from deferred contributions long-term care partnership projects. The undisbursed amount, which represents the present value of future cashflows is recorded as other liabilities (Note 16(b)). Investment income earned on funding received, net of management fees, is recorded as an increase to both the investment base and the deferred contribution.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(j) Internally Restricted Net Assets Invested in Capital Assets

AHS discloses internally restricted net assets invested in capital assets separately on the Consolidated Statement of Financial Position and Consolidated Statement of Changes in Net Assets. The AHS Board has approved the restriction of net assets equal to the net book value of internally funded capital assets.

(k) Grants for Research and Other Initiatives

AHS awards grants to other organizations for research and other initiatives. The terms of the grants range from less than one year to more than one year. AHS records the committed value of the grant awarded as an expense when it has been approved and when the agreement between AHS and the principal investigator has been executed.

(l) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a significant variance between the recognized or disclosed amount and another reasonably possible amount. The amounts recorded for amortization of capital assets and amortization of external capital contributions are based on the estimated useful life of the related assets. The amounts recorded for asset retirement and employee future benefits obligations are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

(m) Capital Disclosure

For operating purposes, AHS defines capital as including working capital and unrestricted net assets. For capital purposes, AHS defines capital as including deferred capital contributions, long term debt, unamortized external capital contributions, and internally restricted net assets invested in capital assets.

AHS's objectives for managing capital are:

- In the short term, to safeguard its financial ability to continue to deliver health services; and
- In the long term, to plan and build sufficient physical capacity to meet future needs for health services.

The majority of AHS's operating funds are from AHW. AHW provides the operating funds on the first of each month. AHS monitors and forecasts its working capital and cash flow as part of its ongoing cash management activities.

AHW approves health care facilities based on long-term capital plans and AI provides the majority of the funding through one-time capital grants. AHS funds the required equipment and systems by a combination of allocating a portion of operating funds and obtaining external funding from charitable donations and capital grants. AHS borrows to finance capital investments related to ancillary operations, which includes parking and rental operations, non-patient food services and the sale of goods and services, since AHW and AI do not fund ancillary operations.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

AHS complied with all debt covenants during the year. In the event of default, the entire outstanding indebtedness secured by and payable to Alberta Capital Financing Authority (ACFA), at their option, becomes due and payable forthwith and without notice to AHS. ACFA may also elect to retain all or any part of the collateral in satisfaction of the indebtedness of AHS. AHS monitors and forecasts all debt covenants as part of its ongoing debt management activities.

Where AHS has incurred an accumulated deficit, legislation requires submission of a deficit elimination plan.

(n) Changes to Accounting Framework

The Public Sector Accounting Board of the CICA has issued a framework for financial reporting by government not-for-profit organizations. This framework will be effective for fiscal periods beginning on or after January 1, 2012.

Effective April 1, 2012, AHS will adopt the Canadian Public Sector Accounting (PSA) standards without the Public Sector 4200 series. Adopting these new standards will impact AHS's consolidated financial statements. AHS has developed a PSA transition plan and has identified the major differences between current and PSA accounting and reporting standards. Two of these differences include:

- Sick leave obligations – AHS will be required to record accumulating non-vesting sick leave obligations.
- Controlled foundations – AHS will be required to consolidate its controlled foundations currently disclosed in Note 21(c)(i).

AHS continues to work through this transition and the remaining differences; the quantitative impact cannot be fully and reasonably determined at this time.

Note 3 Restatements

(a) Long-term Care Partnerships Adjustment

In prior years, AHS accounted for loans advanced to contracted health service providers under the Forgivable Mortgage Model. Under this model, advances were recognized as assets amortized over the useful life of the funded infrastructure and expensed to facility-based continuing care services and community based care. If the loans were provided from funds contributed to AHS, an equal amount of revenue was recognized as other government contributions from deferred contributions.

AHS has determined that forgivable mortgages are in substance contributions by AHS to contracted health service providers and, therefore, it is more appropriate to expense the advances when the forgivable mortgage contracts create an obligation and to recognize an equal amount of revenue from deferred contributions. Consistent with this conclusion, AHS has also determined that commitments to make payments to contracted health service providers under the Supplementary Payments Model should be expensed and recorded as a liability when the contracts create an obligation.

Note 3 Restatements (continued)

(b) Full Cost Adjustment

In prior years, AHS accounted for revenue earned by contracted health service providers from AHW designated fees and charges as AHS fees and charges and recorded an equivalent amount as program expenses on the basis that this revenue funded part of the cost of AHS's programs. As AHS is not entitled to these fees and charges, AHS has concluded it is not appropriate to gross up these fees and charges on AHS's financial statements. Consistent with this conclusion, AHS has also determined that grossing up government contributions and program expenses for the estimated cost for use of acute care facilities not owned by AHS is not appropriate.

(c) Commitments and Contingencies

In 2012, AHS changed its contingencies disclosure reporting practice to disclose only those legal claims, where:

- it is likely that a future event will confirm a contingent loss at the date of the financial statements but the amount of loss cannot be reasonably estimated;
- the occurrence of a future event confirming a contingent loss is not reasonably determinable; or
- the occurrence of the confirming future event is likely and an accrual has been made but there exists an exposure to loss in excess of the amount accrued.

As a result of this change, the prior year figures for claims disclosed in Note 20(d) have been reduced from 361 claims ($325,490) to 114 claims ($145,943).

(d) Reclassifications

Certain 2011 amounts have been reclassified to conform to the 2012 presentation.

The impact on the prior year's consolidated financial statements as a result of these restatements is presented in Schedule 4.

Note 4 Budget

The 2011/2012 Operating Budget and Business Plan with a budgeted deficit of $20,000, was approved by the Board on June 10, 2011 and the full financial plan was submitted to the Minister. The reported budget reflects the original $20,000 deficit and additional reclassifications required for more consistent presentation with current and prior year results (Schedule 3), including restatements for long-term care partnerships (Note 3(a)) and full cost (Note 3 (b)).

Note 5 Unrestricted Deficit Funding

AHS started on April 1, 2009 with an opening accumulated deficit from the former health entities. In February 2010 the five-year funding commitment for health was announced, including funding the accumulated deficit of AHS after the first year of operations. In the prior year, $527,235 in deficit funding was received as a part of this commitment.

Note 5 Unrestricted Deficit Funding (continued)

The Consolidated Statement of Operations reports the operating surplus including the deficit funding. The operating surplus excluding the deficit funding is as follows:

	2012	2011
Operating surplus	$ 84,591	$ 856,155
Less: Deficit funding	-	(527,235)
Operating surplus excluding deficit funding	$ 84,591	$ 328,920

Note 6 Investment and Other Income

	2012	2011 Restated (Note 3)
Investment income	$ 36,631	$ 69,799
Other income:		
External recoveries	125,911	140,542
Grants and other revenue	67,631	57,026
Purchase incentives and rebates	18,126	7,842
	$ 248,299	$ 275,209

Note 7 Administration Expense

	2012	2011 Restated (Note 3)
General administration[a]	$ 134,992	$ 92,810
Human Resources	104,109	90,119
Finance	67,781	62,845
Administration - contracts with health service providers	57,039	58,451
	$ 363,921	$ 304,225

(a) General Administration

General administration includes senior executive and administrative functions such as communications, planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal. Activities and costs directly supporting clinical activities are excluded.

Note 8 Pension Expense

	2012	2011 Restated (Note 3)
Local Authorities Pension Plan (LAPP)[a]	$ 361,575	$ 321,919
Defined contribution pension plans and Group RRSPs	16,772	12,922
Costs to transfer employees to LAPP	5,169	-
Supplemental Executive Retirement Plans	3,770	3,351
Management Employees Pension Plan (MEPP)[b]	661	90
Supplemental Pension Plan	523	458
	$ 388,470	$ 338,740

(a) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP and as AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE) over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

The contribution rates were reviewed by the LAPP Board of Trustees in 2011 and are to be reviewed at least once every three years based on recommendations of the LAPP's actuary. AHS and its employees made the following contributions:

Calendar 2011		Calendar 2010	
Employer	**Employees**	**Employer**	**Employees**
$ 357,632	$ 324,613	$ 314,219	$ 284,303
9.49% of pensionable earnings up to the YMPE and 13.13% of the excess	8.49% of pensionable earnings up to the YMPE and 12.13% of the excess	9.06% of pensionable earnings up to the YMPE and 12.53% of the excess	8.06% of pensionable earnings up to the YMPE and 11.53% of the excess

AHS contributed $357,632 (2010 - $314,219) of the LAPP's total employer contributions of $856,950 from January 1, 2011 to December 31, 2011 (December 31, 2010 - $777,766).

Note 8 **Pension Expense (continued)**

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2010 by Mercer (Canada) Limited and results were then extrapolated to December 31, 2011. LAPP's net assets available for benefits divided by LAPP's pension obligation shows that LAPP is 81% (2010 – 79%) funded.

	December 31, 2011	December 31, 2010
LAPP net assets available for benefits	$ 19,662,810	$ 17,686,850
LAPP pension obligation	24,302,200	22,322,100
LAPP deficit	$ (4,639,390)	$ (4,635,250)

Further information about the LAPP including assumptions and sensitivities of the LAPP's deficiency to changes in those assumptions can be found in the LAPP financial statements and the LAPP annual report.

The 2012 and 2013 LAPP contribution rates have been increased as follows:

Calendar 2013 (estimated)		Calendar 2012	
Employer	**Employees**	**Employer**	**Employees**
10.43% of pensionable earnings up to the YMPE and 14.47% of the excess	9.43% of pensionable earnings up to the YMPE and 13.47% of the excess	9.91% of pensionable earnings up to the YMPE and 13.74% of the excess	8.91% of pensionable earnings up to the YMPE and 12.74% of the excess

(b) Management Employees Pension Plan (MEPP)

At December 31, 2011 the MEPP reported a deficit of $517,726 (2010 – deficit of $397,087).

Note 9 Cash, Cash Equivalents and Investments

	2012		2011	
	Fair Market Value	Cost	Fair Market Value	Cost
Cash	$ 504,538	$ 504,538	$ 457,951	$ 457,951
Money market securities < 90 day maturity	258,823	258,823	614,132	614,132
Money market securities > 90 day maturity	73,267	73,267	-	-
Fixed income securities	1,288,582	1,281,964	1,220,750	1,230,108
Equities	27,038	27,057	27,967	25,678
	$ 2,152,248	$ 2,145,649	$ 2,320,800	$ 2,327,869
Classified for Financial Instruments as:				
Available for sale	$ 2,030,581	$ 2,025,665	$ 2,225,985	$ 2,235,095
Held for trading	121,667	119,984	94,815	92,774
	$ 2,152,248	$ 2,145,649	$ 2,320,800	$ 2,327,869

Classified on the Consolidated Statement of Financial Position as:	2012	2011
Current cash	$ 299,877	$ 150,011
Money market securities < 90 day maturity	258,823	614,132
Current cash and cash equivalents	558,700	764,143
Current investments	1,217,043	957,322
Non-current cash and investments	376,505	599,335
Total cash, cash equivalents and investments	$ 2,152,248	$ 2,320,800

In order to earn optimal financial returns at an acceptable level of risk, AHS has established an investment bylaw with maximum asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities. Risk is reduced through asset class diversification, diversification within each asset class, and quality constraints on fixed income securities and equity investments.

(a) Interest Rate Risk

AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

Money market securities are comprised of Government of Canada, provincial and corporate treasury bills maturing June 2012 and bearing interest at an average effective yield of 1.00% (2011 – 0.74%) per annum.

Fixed income securities, such as bonds, have an average effective yield of 1.80% (2011 – 2.07%) per year, maturing between 2012 and 2044. The securities have the following maturity structure:

	2012	2011
1 – 5 years	87%	88%
6 – 10 years	10%	9%
Over 10 years	3%	3%

Note 9 Cash, Cash Equivalents and Investments (continued)

(b) Currency Rate Risk

AHS is exposed to foreign exchange fluctuations on its investments denominated in foreign currencies. However, this risk is managed by the fact that AHS's investment bylaw limits non-Canadian equities to 25% of the total investment portfolio. As at March 31, 2012, investments in non-Canadian equities represented 0.50% (2011 – 0.57%) of total investments.

(c) Credit and Market Risks

AHS is exposed to credit risk from the potential non-payment of accounts receivable. However, the majority of the value of AHS's receivables is from AHW; therefore credit risk is considered to be minimal.

AHS's investment by-law restricts the types and proportions of eligible investments, thus mitigating AHS's exposure to market risk. Money market securities are limited to a rating of R1 or equivalent or higher and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total investment portfolio. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. Short selling is not permitted.

(d) Restricted Funds for Long Term Insurance Obligations

Included in restricted funds are cash and investments held by AHS to meet long term liability and property insurance obligations. Amounts totaling $96,472 (2011 - $85,386) are restricted to satisfy the reserve and guarantee funds requirement under the *Insurance Act* (Alberta) related to the provision for unpaid claims (Note 16(a)).

(e) Restricted Cash

Current cash and cash equivalents and current investments include a restricted amount of $723,695 (2011 - $550,555), and non-current cash and investments includes $204,661 (2011 - $307,940) of restricted cash and $171,844 of restricted investments (2011 - $291,395).

Note 10 Capital Assets

	2012		
	Cost	Accumulated Amortization	Net Book Value
Facilities and improvements	$ 6,138,968	$ 2,293,008	$ 3,845,960
Work in progress	2,109,881	-	2,109,881
Equipment	1,898,642	1,282,031	616,611
Information systems	932,565	646,573	285,992
Building service equipment	381,646	216,804	164,842
Land	109,429	-	109,429
Leased facilities and improvements	165,013	97,007	68,006
Land improvements	64,753	50,303	14,450
	$ 11,800,897	$ 4,585,726	$ 7,215,171

Note 10 Capital Assets (continued)

	2011		
	Cost	Accumulated Amortization	Net Book Value
Facilities and improvements	$ 6,001,128	$ 2,118,659	$ 3,882,469
Work in progress	1,669,214	-	1,669,214
Equipment	1,740,143	1,160,474	579,669
Information systems	757,329	541,302	216,027
Building service equipment	349,066	194,307	154,759
Land	108,830	-	108,830
Leased facilities and improvements	162,892	81,900	80,992
Land improvements	63,512	48,008	15,504
	$ 10,852,114	$ 4,144,650	$ 6,707,464

(a) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease expiry
Cross Cancer Institute parkade	University of Alberta	2019
Banff Health Unit	Mineral Springs Hospital	2028
Evansburg Community Health Centre	Yellowhead County	2031
Two Hills helipad	Stella Stefiuk	2041
Northeast Community Health Centre	City of Edmonton	2046
Foothills Medical Centre parkade	University of Calgary	2054
McConnell Place North	City of Edmonton	2056
Alberta Children's Hospital	University of Calgary	2101

(b) Work in Progress

During the year Alberta Infrastructure contributed $495,328 (2011 - $105,966) of in-kind work in progress to AHS.

(c) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $11,496 (2011 - $12,250) with accumulated amortization of $10,721 (2011 - $10,938).

Note 11 Other Assets

		2012		2011 Restated (Note 3)
Capital contributions receivable	$	92,175	$	76,937
Accrued benefit asset of SERPs [(a)]		11,636		12,511
Other non-current assets		25,682		6,656
	$	129,493	$	96,104

(a) Supplemental Executive Retirement Plans (SERPs)

During the year there were three SERPs sponsored by AHS. Under their terms, participants will receive retirement benefits that supplement the benefits under AHS's registered plans that are limited by the *Income Tax Act* (Canada). As required under the plans' terms, any unfunded obligations identified in the actuarial valuation completed at the end of each fiscal year must be fully funded within 61 days. The accounting policies for SERPs are described in Note 2(h).

During 2012, the AHS Board approved amendments to the defined benefit SERPs which will freeze SERP service accruals and earnings projections for all active plan members over a 3 year period. Once individual plan members' SERP service accruals are frozen, these plan members will be enrolled and accrue benefits in the new defined contribution SPP. The plan amendments described above meet the definition of a curtailment event. The curtailment event resulted in a decrease to the accrued benefit obligation of $1,251 and a corresponding $1,251 decrease in unrecognized net actuarial losses.

		2012		2011
Change in accrued benefit obligation				
Accrued benefit obligation, beginning of year	$	34,143	$	31,809
Current service cost		1,774		1,668
Interest cost		1,704		1,754
Benefit payments		(1,956)		(2,159)
Decrease in obligation due to curtailment		(1,251)		-
Actuarial losses		771		1,071
Accrued benefit obligation, end of year	$	35,185	$	34,143
Change in plan assets				
Fair value of plan assets, beginning of year	$	40,095	$	32,367
Adjustment to opening value		932		(984)
Actual return on plan assets		1,738		1,189
Actual employer contributions		2,895		9,682
Benefit payments		(1,956)		(2,159)
Fair value of plan assets, end of year	$	43,704	$	40,095
Reconciliation of funded status to accrued benefit asset				
Funded status of the plan	$	8,519	$	5,952
Unrecognized net actuarial losses		3,008		5,921
Unrecognized initial obligations		57		342
Unrecognized past service cost		52		296
Accrued benefit asset, end of year	$	11,636	$	12,511

Note 11 Other Assets (continued)

	2012	2011
Determination of net benefit cost		
Current service cost	$ 1,774	$ 1,668
Interest cost	1,704	1,754
Net return on plan assets	58	(887)
Net actuarial losses (gains) in year	(295)	166
Amortization of initial obligations and past service costs	529	650
Plan amendment – curtailment	(1,251)	-
Accelerated recognition of unamortized actuarial loss due to curtailment	1,251	-
Net benefit cost	$ 3,770	$ 3,351
Members		
Active	51	60
Retired and terminated	52	48
Total members	103	108
Assumptions		
Weighted average discount rate to determine year end obligations	4.80%	4.90%
Weighted average discount rate to determine net benefit costs	4.90%	5.40%
Expected return on assets	2.13%	2.70%
Expected average remaining service life time	3	5
Rate of compensation increase per year	3.5% for 2012 until notice period end date	2011-2012 1.5% 2012-2013 2.5% Thereafter 3.5%

Note 12 Deferred Contributions

Deferred contributions represent unspent externally restricted resources. Changes in the deferred contributions balance are as follows:

	2012			2011
	AHW	Others	Total	Total Restated (Note 3)
Balance beginning of the year	$ 415,322	$ 192,299	$ 607,621	$ 576,034
Received or receivable during the year	695,868	174,557	870,425	947,954
Restricted investment income	2,561	1,719	4,280	6,090
Transferred from (to) deferred capital contributions	(4,192)	11,614	7,422	2,123
Contribution and investment income recognized as revenue	(838,227)	(201,161)	(1,039,388)	(924,580)
Balance end of the year	$ 271,332	$ 179,028	$ 450,360	$ 607,621

Note 12 Deferred Contributions (continued)

The balance at the end of the year is restricted for the following purposes:

	2012 AHW	2012 Others	2012 Total	2011 Total Restated (Note 3)
Research and education	$ 1,813	$ 79,363	$ 81,176	$ 79,278
Addiction and mental health	77,544	1,618	79,162	109,470
Primary Care Networks (Note 21(b))	41,946	622	42,568	41,946
Virtual site training for Calgary South Health Campus	41,982	-	41,982	49,630
Cancer prevention, screening and treatment	32,922	4,329	37,251	38,329
Physician revenue and Alternate Relationship Plans	28,305	-	28,305	54,410
Infrastructure maintenance	22	26,776	26,798	38,205
Promotion, prevention and community	18,002	4,532	22,534	40,980
Administration and support services	421	14,565	14,986	12,135
Continuing care and seniors health	11,494	2,495	13,989	52,620
Inpatient acute nursing services	937	12,796	13,733	19,426
Emergency and outpatient services	7,642	5,210	12,852	21,049
Diagnostic and therapeutic services	1,978	8,292	10,270	12,305
Information technology	3,308	297	3,605	15,369
Others less than $10,000	3,016	18,133	21,149	22,469
	$ 271,332	$ 179,028	$ 450,360	$ 607,621

Note 13 Deferred Capital Contributions

Deferred capital contributions represent unspent externally restricted resources related to capital assets. Changes in the deferred capital contributions balance are as follows:

	2012				2011
	AHW	AI	Others	Total	Total
Balance beginning of the year	$ 214,607	$ 267,281	$ 59,968	$ 541,856	$ 1,046,140
Received or receivable during the year	40,867	35,901	67,589	144,357	156,757
Received in kind	-	495,328	-	495,328	106,052
Restricted investment income	1,889	-	-	1,889	965
Capital contributions returned[(a)]	(7,917)	(81,441)	(7,842)	(97,200)	(58,850)
Transferred to unamortized external capital contributions	(60,067)	(619,959)	(38,864)	(718,890)	(710,815)
Transferred from (to) deferred contributions	4,192	(14,551)	2,937	(7,422)	(2,123)
Other	-	-	-	-	3,730
Balance end of the year	$ 193,571	$ 82,559	$ 83,788	$ 359,918	$ 541,856

(a) Payment to AI for capital contribution returned did not occur by March 31, 2012.

Note 13 Deferred Capital Contributions (continued)

The balance at the end of the year is restricted for the following purposes

	2012	2011
AHW		
Information systems:		
Regional Shared Health Information Program	$ 34,540	$ 44,979
Diagnostic Imaging Project Year 3	25,844	29,004
Diagnostic Imaging Project Year 4	22,142	26,219
Provincial Health Information Exchange	9,128	10,909
Others less than $10,000	71,248	75,971
	162,902	187,082
Equipment less than $10,000	30,669	27,525
Total AHW	193,571	214,607
AI		
Facilities and improvements:		
Infrastructure maintenance projects	38,868	143,009
Others less than $10,000	43,691	124,272
Total AI	82,559	267,281
Other		
Equipment less than $10,000	74,495	31,155
Facilities and improvements less than $10,000	9,293	28,813
Total Other	83,788	59,968
Total	$ 359,918	$ 541,856

Note 14 Long-term Debt

	2012	2011
Debentures payable: [a]		
Parkade loan #1	$ 44,528	$ 46,683
Parkade loan #2	40,510	42,303
Parkade loan #3	49,744	51,582
Parkade loan #4	178,292	15,000
Parkade loan #5	10,000	5,000
Calgary Laboratory Services purchase	10,179	16,583
Term loan-Parkade #4	-	138,000
Term loan-Parkade #5 [b]	19,000	2,000
Obligation under capital lease [c]	15,280	15,328
Other	2,446	3,820
	$ 369,979	$ 336,299
Current	$ 38,802	$ 153,799
Non-current	331,177	182,500
	$ 369,979	$ 336,299
Fair value of total long-term debt [d]	$ 423,165	$ 345,325

(a) AHS issued debentures to ACFA, a related party, to finance the construction of parkades and the purchase of the remaining 50.01% ownership interest in CLS. AHS has pledged as security for these debentures revenues derived directly or indirectly from the operations of all parking facilities being built, renovated, owned and operated by AHS.

As at March 31, 2012, $10,000 (2011 - $5,000) of $42,300 has been advanced to AHS relating to the Parkade loan #5 debenture with the remaining to be drawn by June 1, 2012. Semi-annual principal payments of $1,577 will commence December 1, 2012.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Calgary Laboratory Services purchase	May 2013	4.6810%

(b) AHS obtained a term loan facility of $42,300 during 2011, of which $19,000 (2011 - $2,000) has been drawn at March 31, 2012. The facility has been secured by the issuance of the Parkade #5 debenture to ACFA. Although the loan is repayable on demand, repayment terms are for monthly payment of interest only at 2.89%, with the full principal repayment due upon maturity on June 1, 2012.

(c) The capital lease with the University of Calgary expires January 2028. The implicit interest rate payable on this lease is 6.5%.

(d) The fair value of long-term debt is estimated based on market interest rates from ACFA for debentures of similar maturity. AHS manages the interest rate risk exposure of its long-term debt by concentrating the majority of its financial liabilities in fixed rate debt, which provides stable and predictable cash outflows.

Note 14 Long-term Debt (continued)

(e) As at March 31, 2012 AHS held a $220,000 revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.5% per annum. As at March 31, 2012, AHS has no draws against this facility.

AHS also holds a $33,000 revolving demand letter of credit facility which may be used to secure AHS's obligations to third parties relating to construction projects and SERPs. As at March 31, 2012, AHS had $5,353 (2011 - $6,024) in letters of credit outstanding against this facility.

AHS is committed to making payments as follows:

	Debentures Payable, Term/Other Loan and Mortgages Payable	Capital Lease
Year ended March 31	Principal payments	Minimum lease payments
2013	$ 38,286	$ 1,827
2014	17,347	1,693
2015	14,533	1,532
2016	15,221	1,453
2017	15,943	1,453
Thereafter	253,369	16,845
	$ 354,699	24,803
Less: interest		9,523
		$ 15,280

During the year, the amount of interest expensed was $9,009 (2011 - $7,954).

The principal payments due in 2013 for lease payments are $856.

Note 15 Unamortized External Capital Contributions

Unamortized external capital contributions at year-end represent the external capital contribution to be recognized as revenue in future years. Changes in the unamortized external capital contributions balance are as follows:

	2012	2011
Balance beginning of year	$ 5,598,973	$ 5,254,711
Transferred from deferred capital contributions	718,890	710,815
Less deferred capital contributions used for the purchase of land	(599)	(2,500)
Less amounts recognized as revenue:		
Amortized external capital contributions:		
Equipment	(113,893)	(129,551)
Information systems	(39,167)	(52,326)
Facilities and improvements	(189,245)	(182,304)
Ancillary operations	(245)	(425)
Other	-	553
Balance end of year	$ 5,974,714	$ 5,598,973

Note 16 Other Liabilities

	2012	2011 Restated (Note 3)
Provision for unpaid claims [(a)]	$ 101,619	$ 76,802
Long-term care partnerships [(b)]	23,875	34,575
Life lease deposits [(c)]	12,363	12,814
Asset retirement obligations [(d)]	4,852	11,058
Other	5,010	9,291
	$ 147,719	$ 144,540

(a) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported. The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals, on historical precedent and trends, on prevailing legal, economic, and social and regulatory trends, and on expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materiality from the best estimates made.

The fair value of unpaid claims is not practicable to determine with sufficient reliability. Under accepted actuarial practice, the appropriate value of the claims liabilities is the discounted value of such liabilities plus the provision for adverse deviation. The provision for unpaid claims has been estimated using the discounted value of claim liabilities using a discount rate of 2.10% (2011 – 3.25%).

(b) Long-term Care Partnership Agreements

Under some long-term care partnership agreements, AHS makes annual payments to the partner over the term of the partnership contract, which is usually the expected useful life of the infrastructure. Amounts invested under the terms of long-term care partnership agreements will be utilized to fund future payments to providers over the next 22 years. These payments have a net present value of $23,438 at March 31, 2012 (2011 - $20,695) discounted at 2.6% (2011 – 3.7%).

(c) Life Lease Deposits

Funding for the Laurier House facilities, a project for long-term care residents in Edmonton, is provided by the tenants with a non-interest bearing repayment deposit, for the right to occupy the unit they are leasing. When the life lease agreement is terminated, which may be by death of the tenant or the tenant moving out, the life lease deposit is returned to the tenant without interest and in accordance with the terms of the Life Lease Agreement. The liability for life lease deposits is based on a discharge rate of 25% (2011 – 25%) and a discount rate of 1.65% (2011 - 2.2%), representing the bank secured lending rate. The reported liability is based on estimates and assumptions with respect to events extending over a 4 year period using the best information available to management. The carrying value of the reported liability approximates fair value.

Note 16 Other Liabilities (continued)

(d) Asset Retirement Obligation

The asset retirement obligation (ARO) represents the legal obligation associated with the removal of asbestos during planned renovations of AHS facilities. The total undiscounted amount of the estimated cash flows required to settle the recorded obligation is $4,928 (2011 - $11,125), which has been discounted using a weighted average credit-adjusted risk free rate of 1.7% (2011 - 2.2%). Payments to settle the ARO are expected to occur by 2013. AHS has identified the existence of asbestos in other buildings which is not required to be remediated at this time and therefore is not recorded as an obligation.

Note 17 Other Internally Restricted Net Assets

	2012	2011
South Health Campus [a]	$ 45,016	$ 50,000
Parkade infrastructure reserve [b]	24,522	16,722
	$ 69,538	$ 66,722

(a) The AHS Board has approved the restriction of operating surplus to assist with funding start up costs for South Health Campus in Calgary.

(b) The AHS Board has approved the restriction of parking services surpluses to establish a parking infrastructure reserve for future major maintenance, upgrades and construction.

Note 18 Endowments

	2012	2011
Cancer Research Institute of Alberta Director Research Chair [a]	$ 10,000	$ 10,000
J.K. Bigelow Education Fund [b]	150	150
	$ 10,150	$ 10,150

(a) The Cancer Research Institute of Alberta (CRIA) Director Research Chair endowment is internally restricted and is designated for use as a Research Chair for the Director of CRIA. The principal amount of $10,000 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for the salary, infrastructure and operating grant support for the CRIA Director Research Chair.

(b) The J.K. Bigelow Education Fund endowment is internally restricted and is designated for funding of health related courses undertaken by employees of AHS in the Lethbridge area. The principal amount of $150 is required to be maintained and all investment proceeds are available for use. Investment proceeds from the fund are used for education.

Note 19 Changes in Non-Cash Working Capital

The increase (decrease) in non-cash working capital is comprised of:

	2012	2011 Restated (Note 3)
Current investments	$ (259,721)	$ (738,403)
Accounts receivable	(37,464)	(34,486)
Contributions receivable from AHW	122,060	(121,080)
Inventories	2,357	9,242
Prepaid expenses	(154)	(4,043)
Accounts payable and accrued liabilities	61,324	183,578
Accrued vacation pay	42,621	18,338
Deferred contributions	(157,261)	25,438
	$ (226,238)	$ (661,416)
Related to:		
Operating	$ (245,106)	$ (737,874)
Investing	18,868	76,458
	$ (226,238)	$ (661,416)

Note 20 Commitments and Contingencies

(a) Leases

AHS is contractually committed to future operating lease payments for premises and vehicles until 2029 and 2017 respectively as follows:

	Premises	Vehicles	Total
2013	$ 43,140	$ 2,848	$ 45,988
2014	32,627	2,269	34,896
2015	29,395	1,776	31,171
2016	25,085	639	25,724
2017	20,786	20	20,806
Thereafter	58,704	-	58,704
	$ 209,737	$ 7,552	$ 217,289

(b) Capital Assets

AHS has the following outstanding contractual commitments for capital assets as of March 31:

	2012
Equipment	$ 114,039
Facilities and improvements	85,353
Information systems	49,663
	$ 249,055

Note 20 Commitments and Contingencies (continued)

(c) Contracted Health Service Providers

AHS contracts on an ongoing basis with voluntary and private health service providers to provide health services in Alberta as disclosed in Note 21(d). AHS has contracted for services in the year ending March 31, 2013 similar to those provided by these providers in 2012.

(d) Contingencies

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

At March 31, 2012, AHS has been named in 7 claims (2011 – 14 claims) where it is likely that a future event will confirm a contingent loss. The amount of loss cannot be reasonably estimated and no liability is recorded for these claims (2011 – nil). At March 31, 2012, AHS has been named in 158 legal claims (2011 – 100 claims) where the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 137 claims have $234,873 in specified amounts and 21 have no specified amounts (2011 – 84 claims with $145,943 of specified claims and 16 claims with no specified amounts).

AHS has been named as a defendant in a legal action in respect of increased long-term care accommodation charges levied since August 1, 2003. The claim has been filed against the Government of Alberta and the former Regional Health Authorities (now AHS). The amount of the claim has not been specified but has been estimated to be between $100,000 and $175,000 per year based on the amount of the increases in accommodation charges levied, starting August 1, 2003. The outcome of the claim is not determinable at this time.

AHS has a contingent liability in respect of a claim relating to the failure of St. Joseph's Hospital to provide adequate infection control and safety measures to prevent contamination of medical equipment. The total amount of this claim is $25,000. The outcome of the claim is not determinable at this time.

Note 21 Related Parties

Transactions with the following related parties are considered to be in the normal course of operations. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

(a) Government of Alberta

The Minister of Health and Wellness appoints the AHS Board members. AHS is economically dependent on AHW since the viability of its operations depends on contributions from AHW. Transactions between AHS and AHW are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements.

Note 21 Related Parties (continued)

AHS shares a common relationship and is considered to be a related party with those entities consolidated or included on a modified equity basis in the Province of Alberta's financial statements. Transactions in the normal course of operations between AHS and the other ministries are recorded at their exchange amount as follows:

	Revenue		Expenses	
	2012	2011	2012	2011
Ministry of Advanced Education (i)	$ 50,364	$ 24,298	$ 125,806	$ 121,472
Ministry of Infrastructure (ii)	42,218	37,641	16	539
Other ministries	47,814	28,579	24,571	19,630
Total for the year	$ 140,396	$ 90,518	$ 150,393	$ 141,641

	Receivable from		Payable to	
	2012	2011	2012	2011
Ministry of Advanced Education (i)	$ 36,734	$ 5,396	$ 21,714	$ 24,219
Ministry of Infrastructure (ii)	61,886	39,227	151,248	12,951
Other ministries	6,429	9,630	338,571	180,572
Balance at end of the year	$ 105,049	$ 54,253	$ 511,533	$ 217,742

(i) Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared cost.

(ii) The transactions with the Ministry of Infrastructure relate to the construction and funding of capital assets (Notes 10(b) and 13).

Note 21 Related Parties (continued)

(b) Primary Care Networks

AHS has joint control with various physician groups over Primary Care Networks (PCNs). AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services. Effective April 1, 2011, the Tri-Lateral Master Agreement between AHS, AHW and Alberta Medical Association expired. While a new agreement is currently being discussed, the joint venture agreements continue to direct the management and operation of the PCNs.

There are two legal models of PCNs, both of which are considered to be non-profit organizations under the income tax legislation. Legal model 1 consists of a joint venture agreement between AHS and the Physician non-profit corporation (NPC) with funding flowing to the Physician NPC from AHW. Legal model 2 is a PCN NPC owned equally by AHS and the Physician NPC with funding flowing to the PCN NPC from AHW. Individual physicians contract with the Physician NPC.

As a requirement of AHW, PCNs can only use accumulated surpluses based on an approved surplus reduction plan, and as such, AHS's proportionate share of these surpluses has been recorded by AHS as restricted deferred contributions. The following PCNs are included in these consolidated financial statements under the proportionate consolidation method:

Alberta Heartland Primary Care Network
Athabasca Primary Care Network
Big Country Primary Care Network
Bonnyville / Aspen Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace River Primary Care Network
Provost/Consort Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park-Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
St. Paul / Aspen Primary Care Network
Vermilion Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

Note 21 **Related Parties (continued)**

AHS's proportionate share of assets, liabilities, revenues and expenses of the PCNs is as follows:

	2012	2011
Total revenue	$ 74,454	$ 67,531
Total expenses	74,454	67,531
Surplus of revenue over expenses	$ -	$ -
Assets:		
Current	$ 46,077	$ 43,110
Non-current	4,450	4,029
Total assets	$ 50,527	$ 47,139
Liabilities:		
Current (i)	$ 50,527	$ 47,139
Total liabilities	$ 50,527	$ 47,139

(i) Included in liabilities are deferred contributions of $42,568 relating to AHS's proportionate share of the surplus (2011 - $41,946) (Note 12).

(c) Foundations

A large number of foundations provide donations of money and services to AHS to enhance health care in various communities throughout Alberta. This financial support to AHS is reflected in donations revenue and capital contributions. These foundations are registered charities under the *Income Tax Act* (Canada) and accordingly, are exempt from income taxes, provided certain requirements of the Income Tax Act are met.

(i) Controlled foundations

A number of foundations are considered to be controlled entities as AHS appoints all trustees for such foundations. Controlled foundations are not consolidated in these consolidated financial statements.

The Alberta Cancer Foundation (ACF) and the Calgary Health Trust (CHT) are the largest controlled foundations. The following aggregated financial results of ACF and CHT is presented using the same accounting policies as AHS:

	2012		2011	
	ACF	CHT	ACF	CHT
Revenue	$ 42,179	$ 34,889	$ 43,872	$ 40,634
Expenses	45,376	34,083	43,276	39,670
Operating surplus (deficiency) of revenue over expenses	$ (3,197)	$ 806	$ 596	$ 964
Total assets	$ 116,676	$ 92,095	$ 118,248	$ 87,572
Total liabilities[1] [2]	41,906	65,191	43,227	64,406
Net assets[1] [2]	$ 74,770	$ 26,904	$ 75,021	$ 23,166

Note 21 Related Parties (continued)

(1) In accordance with donor imposed restrictions ACF must maintain permanently $73,712 (2011 - $72,577) with the investment revenue earned to be used for purposes in accordance with the various purposes established by the donors or the Trustees. A further $39,715 (2011 - $40,780) included in liabilities are deferred contributions that must be used for the purpose of cancer research, prevention and screening initiatives, as well as patient care and support, education and equipment.

(2) In accordance with donor imposed restrictions CHT must maintain permanently $22,812 (2011 - $19,880) with the investment revenue earned to be used in accordance with the various purposes established by the donors or the Board. A further $53,668 (2011 - $53,371) included in liabilities are deferred contributions that must be used for the purpose of capital projects and medical equipment, patient care and program support and medical research.

Financial information for the remaining controlled foundations is not disclosed because AHS does not receive financial information from all these foundations on a timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. These foundations' financial statement balances are immaterial individually and in aggregate relative to AHS. The following are the remaining foundations controlled by AHS as at March 31, 2012:

Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Region Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lacombe Hospital and Care Centre Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

Note 21 Related Parties (continued)

The following foundations are also considered controlled, but are in the process of being wound-up or are considered to be inactive:

- Central Peace Hospital Foundation
- Lakeland Regional Health Authority Foundation
- Peace Health Region Foundation
- Manning Community Health Centre Foundation
- McLennan Community Health Care Foundation
- Vermilion and Region Health and Wellness Foundation

(ii) Other foundations

AHS has an economic interest in a number of foundations as they raise and hold resources to support AHS. AHS appoints one board trustee for such foundations. Financial information for these foundations is not disclosed because AHS does not receive financial information from all these foundations on a consistent and timely basis and the cost and effort of preparing financial information for disclosure exceeds the benefit of doing so. The following are the foundations that AHS has an economic interest in as of March 31, 2012:

- Alberta Children's Hospital Foundation
- Beaverlodge Hospital Foundation
- Black Gold Health Foundation
- Capital Care Foundation
- Chinook Regional Hospital Foundation
- Consort Hospital Foundation
- Coronation Heath Centre Foundation
- Daysland Hospital Foundation
- Devon General Hospital Foundation
- Drayton Valley Health Services Foundation
- Drumheller Area Health Foundation
- Fairview Health Complex Foundation
- Glenrose Rehabilitation Hospital Foundation
- High River District Health Care Foundation
- Hinton Health Care Foundation
- Hythe Nursing Home Foundation
- Northern Lights Regional Health Foundation
- Northwest Health Foundation
- Provost and District Health Foundation
- Queen Elizabeth II Hospital Foundation
- Red Deer Regional Health Foundation
- Regional EMS Foundation
- Rosebud Health Foundation
- Royal Alexandra Hospital Foundation
- Sheep River Health Trust
- St. Paul and District Hospital Foundation
- Stollery Children's Hospital Foundation
- Strathmore District Health Services Foundation
- Sturgeon Community Hospital Foundation
- Taber and District Health Foundation
- Tri-Community Health and Wellness Foundation
- University Hospital Foundation
- Valleyview Health Complex Foundation
- Wainwright and District Community Foundation
- Wetaskiwin Health Foundation

Note 21 Related Parties (continued)

(d) Contracts with Health Service Providers

AHS is responsible for the delivery of health services in the Province. To this end, AHS contracts with various voluntary and private health service providers to provide health services throughout Alberta. The largest of these service providers is Covenant Health; the total amount funded to Covenant Health during the year was $640,982 (2011 - $617,083). As of March 31, 2012, the net book value of capital assets owned by AHS but operated by a voluntary or private health service provider was $137,592 (2011 - $138,036).

AHS has an economic interest through its contracts with certain voluntary and private health service providers as AHS transfers significant resources as follows:

	2012	2011 Restated (Note 3)
Direct funding by AHS to:		
Private Health Service Providers	$ 1,030,674	$ 988,251
Voluntary Health Service Providers	1,009,835	893,259
	$ 2,040,509	$ 1,881,510
Included in the Statement of Operations as follows:		
Inpatient acute nursing services	$ 269,975	$ 254,920
Emergency and other outpatient services	84,166	79,128
Facility-based continuing care services	540,009	496,807
Ambulance services	150,226	143,911
Community-based care	347,281	295,557
Home care	165,222	150,893
Diagnostic and therapeutic services	309,443	291,690
Promotion, prevention and protection services	7,517	7,831
Research and education	4,132	4,083
Administration	57,039	58,451
Information technology	469	490
Support services	105,030	97,749
	$ 2,040,509	$ 1,881,510

Note 21 Related Parties (continued)

(e) Health Benefit Trust of Alberta

AHS is one of more than thirty participants in the Health Benefit Trust of Alberta (HBTA) and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement. The HBTA uses various carriers for the different benefits. The HBTA is exempt from the payment of income taxes.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $57,081 as at December 31, 2011 ($79,576 as at December 31, 2010). Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust. However, AHS has included in prepaid expenses $41,494 (2011 - $44,118) as a share of the HBTA's fund balances representing in substance a prepayment of future contributions. For the period January 1 to December 31, 2011 AHS paid premiums of $232,162 (2011 - $132,121).

Note 22 Trust Funds

AHS receives funds in trust for research and development, education and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2012, the balance of funds held in trust by AHS for research and development is $9,308 (2011 - $7,263).

AHS also receives funds in trust from continuing care residents for personal expenses. These amounts are not included above and are not reflected in these consolidated financial statements.

Note 23 Approval of Consolidated Financial Statements

The consolidated financial statements have been approved by the Alberta Health Services Board.

SCHEDULE 1 - CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2012

	2012		2011
	Budget (Note 4) (Schedule 3)	Actual	Actual Restated (Note 3) (Schedule 4)
Salaries and benefits (Schedule 2)	$ 6,315,000	$ 6,156,248	$ 5,667,428
Contracts with health service providers (Note 21(d))	2,108,000	2,040,509	1,881,510
Contracts under the Health Care Protection Act	19,000	18,434	19,308
Drugs and gases	362,000	387,984	361,468
Medical and surgical supplies	334,000	360,002	330,132
Other contracted services	1,065,000	1,038,221	974,356
Other*	1,093,000	1,221,259	1,060,243
Amortization**	495,000	474,513	470,511
TOTAL EXPENSES BY OBJECT	$ 11,791,000	$ 11,697,170	$ 10,764,956

* Significant amounts included in Other are:			
Building and ground expenses	$ 140,000	$ 170,581	$ 139,787
Equipment expense	146,000	152,498	155,690
Other clinical supplies	122,000	140,848	117,928
Utilities	112,000	108,354	100,614
Minor equipment purchases	58,000	104,090	93,903
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies	66,000	84,465	64,249
Office supplies	51,000	65,474	48,258
Food and dietary supplies	68,000	68,495	67,928
Building rent	37,000	51,718	28,852
Travel	46,000	49,719	48,758
Telecommunications	38,000	50,375	19,795
Insurance	21,000	42,670	20,646
Education	39,000	16,470	13,549
Licenses, fees and membership	18,000	15,453	17,564
Others less than $10,000	131,000	100,049	122,722
	$ 1,093,000	$ 1,221,259	$ 1,060,243

** Amortization expense:			
Internally funded equipment	$ 52,000	$ 59,869	$ 33,501
Internally funded information systems	49,000	48,801	48,656
Internally funded facilities and improvements	24,000	22,341	24,341
Externally funded equipment	125,000	111,970	129,379
Externally funded information systems	45,000	39,167	50,773
Externally funded facilities and improvements	200,000	189,646	181,420
Loss on disposal of assets	-	2,719	2,441
	$ 495,000	$ 474,513	$ 470,511

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012

	2012								2011	
						Severance (e)				
	FTE (a)	Base Salary (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Number of Individuals	Amount	Total	FTE (a)	Total (f)(g)
Total Board	13.70	$ -	$ 699	$ -	$ 699	-	$ -	$ 699	13.37	$ 730
Total Executive	9.71	3,504	720	955	5,179	2	1,174	6,353	10.98	6,339
Management Reporting to CEO Reports	34.49	9,401	1,272	2,607	13,280	1	180	13,460	36.54	14,042
Other Management	3,808.28	412,821	9,829	85,490	508,140	69	3,732	511,872	3,479.87	446,389
Medical Doctors not included above	133.44	37,717	495	2,441	40,653	-	17	40,670	150.33	44,314
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	16,770.85	1,432,619	230,278	318,951	1,981,848	16	782	1,982,630	16,556.79	1,834,632
LPNs	3,574.86	212,011	33,141	44,854	290,006	4	272	290,278	3,349.26	255,914
Other Health Technical & Professionals	13,907.65	1,084,772	84,836	247,487	1,417,095	24	865	1,417,960	13,169.46	1,277,308
Unregulated Health Service Providers	6,642.88	301,937	44,018	64,297	410,252	17	372	410,624	6,303.75	347,093
Other Staff	21,649.37	1,175,179	65,776	231,931	1,472,886	140	3,647	1,476,533	21,560.54	1,440,667
Costs to transfer employees to LAPP	-	-	-	5,169	5,169	-	-	5,169	-	-
Total	**66,545.23**	**$ 4,669,961**	**$ 471,064**	**$ 1,004,182**	**$ 6,145,207**	**273**	**$ 11,041**	**$ 6,156,248**	**64,630.89**	**$ 5,667,428**

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

	Term	2012 Committees	2012 Honoraria	2011 Honoraria[7]
Board Chair				
Ken Hughes[1]	May 15, 2008 to Dec 28, 2011	AF, GOV, HA, HR, QS[6]	$ 63	$ 91
Catherine Roozen[2]	Since Jul 29, 2008	AF, GOV, HA, HR, QS[6]	60	57
Board Members				
Don Sieben[3]	Since May 15, 2008	AF(Chair), GOV, HA, HR, QS[6]	56	64
Dr. Ray Block[4]	Since Feb 18, 2011	HR	38	-
Teri Lynn Bougie	Since Nov 20, 2008	HA, QS (Vice-Chair)	54	54
Dr. Ruth Collins-Nakai	Since Feb 18, 2011	HR, QS	53	6
Dr. Kamalesh Gangopadhyay	Since Oct 13, 2010	GOV (Vice-Chair), QS	54	26
Don Johnson	Since Feb 18, 2011	AF (Vice-Chair), HA (Vice-Chair)	56	6
John Lehners	Since May 15, 2008	HA (Chair)	56	58
Irene Lewis	May 15, 2008 to Mar 15, 2012	HR (Chair)	50	51
Stephen Lockwood	Since Oct 13, 2010	GOV (Chair), HR (Vice-Chair)	52	25
Dr. Eldon Smith	Since Feb 18, 2011	AF, GOV	53	5
Sheila Weatherill[5]	Since Feb 18, 2011	AF, GOV	-	-
Gord Winkel	Since Nov 20, 2008	QS(Chair)	54	29
Jack Ady	May 15, 2008 to Aug 31, 2010	-	-	23
Lori Andreachuk	Nov 20, 2008 to Aug 31, 2010	-	-	28
Gord Bontje	Nov 20, 2008 to Nov 24, 2010	-	-	35
Jim Clifford	Nov 20, 2008 to Aug 31, 2010	-	-	23
Strater Crowfoot	Nov 20, 2008 to Mar 31, 2011	-	-	52
Tony Franceschini	Nov 20, 2008 to Nov 24, 2010	-	-	35
Linda Hohol	May 15, 2008 to Nov 25, 2010	-	-	34
Dr. Andreas Laupacis	Nov 20, 2008 to Nov 27, 2010	-	-	28
Total Board			$ 699	$ 730

Board members are compensated with monthly honoraria and honoraria for attendance at board and committee meetings in accordance with Ministerial Order #50. Although M.O. #50 was repealed by M.O. #93, original rates from M.O. #50 were adopted again as of January 1, 2010.

(1) Ken Hughes was Board Chair until December 28, 2011.
(2) Catherine Roozen was Board Vice Chair until being appointed Interim Board Chair from December 28, 2011 until March 15, 2012 at which time she was appointed Board Chair.
(3) Don Sieben was Interim Board Vice Chair from January 17, 2012 until March 15, 2012 at which time he was appointed Board Vice Chair.
(4) Dr. Ray Block started claiming honoraria on July 8, 2011.
(5) Sheila Weatherill does not claim honoraria.
(6) Board Chair and Board Vice Chair, including interims, are Ex-Officio Members on all Committees.
(7) Committee meeting fees were claimed by the Board members in the current year that related to prior year meetings. Therefore, the prior period was restated.

Committee legend: AF = Audit and Finance, GOV = Governance, HA = Health Advisory, HR = Human Resources, QS = Quality and Safety

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

	2012									
For the Current Fiscal Year	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer(h)(j)(l)(y)	1.00	$ 580	$ 88	$ -	$ -	$ 21	$ 232	$ 921	$ -	$ 921
Chief Audit Executive(z)	1.00	200	24	-	-	-	43	267	-	267
Ethics and Compliance Officer(aa)	1.00	209	16	-	-	-	51	276	-	276
CEO Direct Reports										
Executive VP and Chief Operating Officer(h)(m)(bb)	0.73	345	45	-	-	19	89	498	-	498
Executive VP and Chief Financial Officer(h)(m)(bb)	0.27	105	16	-	-	7	33	161	-	161
Acting Chief Financial Officer(n)(z)	0.38	128	19	-	-	1	27	175	-	175
Executive VP and Chief Medical Officer(h)(k)(o)(cc)	1.00	481	61	-	30	24	173	769	-	769
Acting Executive VP and Chief Medical Officer(p)(aa)	0.16	66	-	-	-	-	-	66	-	66
Executive VP and Chief Development Officer (h)(q)(bb)	0.33	112	17	-	-	8	16	153	-	153
Executive VP, People and Partners (h)(r)(bb)	0.54	221	35	-	-	18	39	313	-	313
Acting Executive VP, People and Partners (h)(s)(bb)	0.46	185	29	-	-	14	48	276	-	276
Executive VP, Strategy and Performance(h)(t)	0.78	288	45	-	6	31	49	419	436	855
Executive VP, Rural, Public and Community Health(h)(u)	0.16	60	-	-	-	2	18	80	-	80
Executive VP and Executive Lead Transition(l)(v)	0.90	335	58	-	52	6	78	529	738	1,267
Chief of Staff for the AHS Board(w)(aa)	0.94	179	27	-	-	1	58	265	-	265
Chief of Staff, Board Office and VP Community Engagement(x)(aa)	0.06	10	-	-	-	-	1	11	-	11
Total Executive	9.71	$ 3,504	$ 480	$ -	$ 88	$ 152	$ 955	$ 5,179	$ 1,174	$ 6,353

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

For the Prior Fiscal Year	2011									
	FTE	Base Salary (b)	Pay-at-Risk Component (b)	Other Variable Pay (b)	Vacation Payouts (b)	Other Cash Benefits (c)	Other Non-Cash Benefits (d)	Subtotal	Severance (e)	Total
Board Direct Reports										
President and Chief Executive Officer[f]	0.65	$ 383	$ -	$ 54	$ 29	$ 48	$ 3	$ 517	$ 681	$ 1,198
Acting President and Chief Executive Officer	0.35	167	-	25	43	4	43	282	-	282
Chief Audit Executive	0.76	151	21	-	-	-	18	190	-	190
Interim VP Internal Audit and Enterprise Risk Management - Contracted Services	0.24	113	-	-	-	-	-	113	-	113
Ethics and Compliance Officer[g]	1.00	209	16	-	-	-	35	260	-	260
CEO Direct Reports										
Executive VP and Chief Financial Officer	1.00	370	55	-	-	33	65	523	-	523
Executive VP, Corporate Services	1.00	370	60	-	-	27	60	517	-	517
Executive VP, Quality and Service Improvement	0.65	307	-	49	190	7	79	632	-	632
Executive VP and Acting Executive Lead for Quality and Service Improvement	0.33	159	-	27	-	-	19	205	-	205
Executive VP, Rural, Public and Community Health	1.00	370	-	62	-	1	106	539	-	539
Executive VP, Strategy and Performance	1.00	370	59	-	-	27	59	515	-	515
Executive VP, Clinical Support Services	1.00	365	-	65	16	2	60	508	-	508
Executive VP and Chief Medical Officer	0.67	323	-	52	92	-	40	507	-	507
Acting Executive VP and Chief Medical Officer	0.33	137	16	-	-	-	-	153	-	153
Chief of Staff, Board Office and VP Community Engagement	1.00	152	-	19	-	-	26	197	-	197
Total Executive	10.98	$ 3,946	$ 227	$ 353	$ 370	$ 149	$ 613	$ 5,658	$ 681	$ 6,339

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

Supplemental Pension Plan (SPP) and Supplemental Executive Retirement Plan (SERP)

	2012				2011				
	SPP	SERP							
	Current Service Costs (1)	Current Service Costs (2)	Other Costs (3)	Total	Total	Account Balance or Accrued Benefit Obligation March 31, 2011	Curtailment (Gain)/Loss (4)	Change During the Year (5)	Account Balance or Accrued Benefit Obligation March 31, 2012
President and Chief Executive Officer until April 1, 2011[l]	$ -	$ -	$ 87	$ 87	$ 172	$ 1,377	$ (68)	$ 61	$ 1,370
President and Chief Executive Officer from April 1, 2011[l]	44	-	-	44	-	-	-	44	44
Chief Audit Executive	6	-	-	6	5	5	-	6	11
Ethics and Compliance Officer	7	-	-	7	14	14	-	7	21
Executive VP and Chief Operating Officer / Executive Vice	30	-	-	30	46	46	-	31	77
Acting Chief Financial Officer[n]	17	-	-	17	-	14	-	17	31
Executive VP and Chief Medical Officer[o]	-	96	40	136	88	599	-	164	763
Acting Executive VP and Chief Medical Officer[p]	-	-	-	-	-	-	-	-	-
Executive VP and Chief Development Officer until November 30, 2011[q]	-	36	38	74	151	655	(56)	79	678
Executive VP and Chief Development Officer from December 1, 2011[q]	7	-	-	7	-	-	-	7	7
Executive VP, People and Partners[r]	15	-	-	15	-	-	-	15	15
Acting Executive VP, People and Partners[s]	23	-	-	23	40	40	-	23	63
Executive VP, Strategy and Performance[t]	18	-	-	18	32	32	-	(32)	-
Executive VP, Rural, Public and Community Health[u]	-	16	17	33	53	725	-	128	853
Executive VP and Executive Lead Transition[v]	-	66	7	73	30	294	(219)	96	171
Chief of Staff for the AHS Board[w]	5	-	-	5	-	-	-	5	5
Chief of Staff, Board Office and VP Community Engagement[x]	1	-	-	1	2	2	-	1	3

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service post 1991. The SPP is a defined contribution plan and the SERP is a defined benefit plan. The SERP is disclosed in Notes 2(h) and 11(a). The amounts in this table represent the total SPP and SERP benefits for the individual in the position listed whereas the amounts included in other non-cash benefits are prorated for the period of time the individual was in the position.

(1) The SPP current service costs are AHS contributions in the period.
(2) The SERP costs are not cash payments in the period but are the cost in the period for rights to these future retirement benefits. Current service cost is the actuarial present value of the benefits earned in the fiscal year.
(3) Other SERP costs include interest cost on the obligations and the amortization of past service cost, initial obligations and net actuarial gains and losses, offset by the expected return on the plans' assets.
(4) As a result of SERP plan amendments which occurred in the current year, an accounting curtailment event was recognized. This resulted in a decrease to the accrued benefit obligation but did not reduce the amount of benefits earned by plan members up to their end of notice period.
(5) Changes in the accrued benefit obligation include current service cost, interest accruing on the obligations, the full amount of any actuarial gains or losses in the period, and gains or losses due to curtailment.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

Definitions

a. For this schedule, Full time equivalents (FTE) are determined by actual hours paid divided by 2,022.75 annual base hours. If applicable, FTE for Board Members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year or the beginning of the year and the termination date. Total actual discrete number of individuals employed during the fiscal year was 106,141 (2011 – 99,386).

b. There are two compensation models for senior leaders. Some receive a base salary with a component that is at risk if they do not meet performance objectives. Others receive a base salary plus other variable pay if they meet performance objectives.

Pay at risk: As new staff is hired or existing contracts end, senior leaders are required to participate in 'pay-at-risk'. Under this model, a component of remuneration is withheld during the year and released (in full or in part) based on achievement of performance objectives.

Other variable pay: Senior leaders with contracts existing prior to formation of AHS may have variable pay provisions in their contracts. Variable pay is in addition to, and calculated as a percentage of, base salary. Variable pay is paid based on achievement of performance objectives.

Vacation payouts, which are a cash benefit, are shown separately for direct reports of the Board or President and Chief Executive Officer. Vacation accruals are included in base salary except for direct reports of the Board or President and Chief Executive Officer where it is included in other non-cash benefits.

c. Other cash benefits may include as applicable honoraria, overtime, automobile allowance, lump sum payments and an allowance for personal, financial and tax advice, club memberships and other similar purposes. For anyone other than direct reports of the Board or the President and Chief Executive Officer, other cash benefits may also include pay at risk or other variable pay if applicable.

d. Other non-cash benefits include:

- Employer's current and prior service cost of supplemental pension plan and supplemental executive retirement plans.
- Share of employee benefits and contributions or payments made on behalf of employees including pension, health care, dental coverage, vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short term disability plans.
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

e. Severance includes direct or indirect payments to individuals upon termination or voluntary exit which are not included in other cash benefits or non-cash benefits.

f. In the prior year, severance of $661 was accrued for the incumbent. However, the final payment to the incumbent included an additional $20 for relocation expenses in accordance with the incumbent's contract. The prior year balance has been restated to reflect the actual severance paid.

g. Subsequent to release of the prior year financial statements, it was determined the incumbent's position should be retroactively included in a higher pay band which resulted in the position being eligible for pay at risk. Therefore, the incumbent was retroactively awarded pay at risk for fiscal 2011. The prior year balance has been restated to reflect the actual pay at risk paid.

h. Incumbents are provided with an automobile allowance. Dollar amounts are included in other cash benefits.

i. Incumbents are provided with an automobile. Dollar amounts are not included in other non-cash benefits.

j. Incumbent was on secondment from the University of Calgary until December 31, 2011. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary, honorarium and market supplements; all amounts have been included in base salary.

k. Incumbent is on secondment from the University of Calgary. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Calgary. AHS reimburses the University for the incumbent's rank salary; all amounts have been included in base salary.

Appointments and Departures

l. Incumbent held the position of Acting President and Chief Executive Officer until March 31, 2011. Incumbent appointed to position of President and Chief Executive Officer effective April 1, 2012 to March 31, 2016.

m. Incumbent held the position of Executive Vice President and Chief Financial Officer until May 31, 2011 at which time the incumbent was appointed to Executive Vice President and Chief Financial Officer and Acting Chief Operating Officer. The Executive Vice President and Chief Operating Officer position was established effective June 1, 2011 as a result of restructuring. The incumbent received acting pay of 10% of the base salary for the Acting Chief Operating Officer position. The incumbent was appointed to Executive Vice President and Chief Operating Officer on July 11, 2011 and retained the position of Acting Chief Financial Officer until November 15, 2011. The incumbent received an increase in base salary for the Executive Vice President and Chief Operating Officer position. Pay at risk has been allocated to each position based on the performance agreement relating to each position.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

n. Incumbent held the position of Senior Vice President, Finance until November 16, 2011 at which time the incumbent was appointed to Acting Chief Financial Officer and became a direct report to the President and Chief Executive Officer. The incumbent received an additional 10% of the base salary for the Acting Chief Financial Officer position. Pay at risk has been allocated to each position based on the performance agreement relating to each position.

o. Incumbent held the position of Executive Vice President and Acting Executive Lead for Quality and Service Improvement until May 31, 2011 at which time the position was abolished as a result of restructuring and the incumbent was appointed to Executive Vice President and Chief Medical Officer. There was no additional compensation for the Executive Vice President and Chief Medical Officer position; however during the fiscal year the incumbent became eligible for pay at risk rather than other variable pay.

p. Position held by incumbent until May 30, 2011.

q. Incumbent held the position of Senior Vice President, Corporate Merger and Information Technology until November 30, 2011 at which time the incumbent was appointed to Senior Vice President and Chief Development Officer and became a direct report to the President and Chief Executive Officer. The Senior Vice President and Chief Development Officer position was established effective December 1, 2011 as a result of restructuring. The title for this position changed to Executive Vice President and Chief Development Officer effective January 10, 2012.

r. Incumbent appointed to position effective September 19, 2011 to September 18, 2016.

s. Incumbent held the position of Executive Vice President, Corporate Services until May 31, 2011 at which time the incumbent was appointed to Acting Executive Vice President, People and Partners. The Executive Vice President, Corporate Services position was abolished and the Executive Vice President, People and Partners position was established effective June 1, 2011 as a result of restructuring. The incumbent received an additional 10% of the base salary for the Acting Executive Vice President, People and Partners position. The incumbent held this position until September 18, 2011 at which point the incumbent was appointed to Senior Vice President, Edmonton Zone. The position of Senior Vice President, Edmonton Zone is not a direct report to the President and Chief Executive Officer. Pay at risk has been calculated based on 50% of the year end results of the Executive Vice President, People and Partners performance agreement and 50% of the year end results for the Senior Vice President, Edmonton Zone performance agreement. The pay at risk disclosed is the pay at risk received for the Executive Vice President, People and Partners position.

t. Position held by incumbent until January 10, 2012. The incumbent received the salary and other accrued entitlements to the date of departure. The reported severance includes 12 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits, both in accordance with the incumbent's contract. Should the incumbent obtain alternate employment during the 12 month notice period, the monthly payments will cease and the incumbent will be paid a lump sum equal to one-half of any payments then remaining. The incumbent received a proportionate amount of pay at risk for the months worked within the fiscal year based on the prior year's pay at risk amount. In addition AHS reimbursed the incumbent for legal costs of $10. AHS will also make payment for the incumbent to attend an outplacement program for a maximum of 6 months.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

u. Incumbent held the position of Executive Vice President, Rural, Public and Community Health until May 31, 2011 at which time the position was abolished as a result of restructuring. The incumbent continued as an employee until August 31, 2011, but was not a direct report to the President and Chief Executive Officer during this time.

v. Incumbent held the position of Executive Vice President, Clinical Support Services until May 11, 2011 at which time the incumbent was appointed to Executive Vice President and Executive Transition Lead. The Executive Vice President, Clinical Support Services position was abolished and the Executive Vice President and Executive Transition Lead position was established effective May 11, 2011 as a result of restructuring. There was no change in compensation for the Executive Vice President and Executive Transition Lead position which was held by incumbent until February 24, 2012. The reported severance includes 18 months base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits, both in accordance with the incumbent's contract. The amount also includes a pay at risk entitlement of $99K related to the 18 month severance period, in accordance with an amendment to the incumbent's contract entered into in the current year. The incumbent received a proportionate amount of pay at risk for the months worked within the fiscal year based on the achievement of the incumbent's individual objectives as outlined in the current year's performance agreement.

w. Incumbent appointed to position effective April 25, 2011.

x. Position held by incumbent until April 24, 2011 at which point the incumbent was relieved of Chief of Staff, Board Office responsibilities. The position of Vice President, Community Relations is not a direct report to the President and Chief Executive Officer.

Termination Liabilities

y. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive a maximum severance pay for 12 months base salary at the rate in effect at the date of termination. The incumbent will also receive 15% of the severance in lieu of all other benefits.

z. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. This severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

aa. The incumbent's termination benefits have not been predetermined.

SCHEDULE 2 - CONSOLIDATED SCHEDULES OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2012 (CONTINUED)

bb. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to 12 months base salary at the rate in effect at the date of termination. Such severance will be paid in 12 equal monthly installments. The incumbent will also be paid 15% of the severance in lieu of all other benefits. Upon obtaining alternate employment, the incumbent is only entitled to receive one-half of the unpaid severance at that time.

cc. In the case of termination without just cause by AHS, the incumbent shall receive the salary and other accrued entitlements to the date of termination. In addition, the incumbent will receive severance pay equal to a maximum of 18 months base salary(k) and premium payments at the rate in effect at the date of termination. The incumbent will also be paid an amount up to 18 months of the total cost of the incumbent's benefits. AHS will also make payment for the incumbent to attend an outplacement program for 6 months.

dd. SPP and SERP

Based on the provision of the applicable SPP and SERP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2011-2012 fiscal period:

Position	Benefit (not in thousands)	Frequency	Payment Terms
Executive VP, Strategy and Performance	$52,199	One-Time	Paid in 2011-2012
Executive VP, Rural, Public and Community Health from September 1, 2011 until December 31, 2011(u)	$4,292	Monthly	4 Months
Executive VP, Rural, Public and Community Health from January 1, 2012(u)	$4,309	Monthly	Indefinite
Executive VP and Executive Lead Transition	$47,546	Annually	3 Years

SCHEDULE 3 - CONSOLIDATED SCHEDULE OF BUDGET
FOR THE YEAR ENDED MARCH 31, 2012

	Original Financial Plan (Note 4)	Adjustments (Note 3)	Reclassifications	Reported Budget
Revenue				
Alberta Health and Wellness contributions				
Unrestricted ongoing	$ 9,582,000	$ -	$ 52,000	$ 9,634,000
Unrestricted deficit funding	-	-	-	-
Restricted	818,000	-	-	818,000
Other government contributions	105,000	(19,000)	27,000	113,000
Fees and charges	645,000	(193,000)	-	452,000
Ancillary operations	117,000	-	-	117,000
Donations	30,000	-	-	30,000
Investment and other income	307,000	-	(70,000)	237,000
Amortization of external capital contributions	370,000	-	-	370,000
TOTAL REVENUE	11,974,000	(212,000)	9,000	11,771,000
Expenses				
Inpatient acute nursing services	2,823,000	(10,000)	(84,000)	2,729,000
Emergency and other outpatient services	1,350,000	7,000	(83,000)	1,274,000
Facility-based continuing care services	935,000	(19,000)	(2,000)	914,000
Ambulance services	372,000	-	7,000	379,000
Community-based care	881,000	(4,000)	106,000	983,000
Home care	445,000	-	(8,000)	437,000
Diagnostic and therapeutic services	2,025,000	12,000	(26,000)	2,011,000
Promotion, prevention and protection services	312,000	-	32,000	344,000
Research and education	230,000	-	(24,000)	206,000
Administration	324,000	(7,000)	75,000	392,000
Information technology	424,000	-	5,000	429,000
Support services	1,675,000	(191,000)	(10,000)	1,474,000
Amortization of facilities and improvements	198,000	-	21,000	219,000
TOTAL EXPENSES	11,994,000	(212,000)	9,000	11,791,000
Operating surplus (deficiency) of revenue over expenses	$ (20,000)	$ -	$ -	$ (20,000)
Expenses by object				
Salaries and benefits	$ 6,212,000	$ -	$ 103,000	$ 6,315,000
Contracts with health service providers	2,166,000	(212,000)	154,000	2,108,000
Contracts under the Heath Care Protective Act	18,000	-	1,000	19,000
Drugs and gases	386,000	-	(24,000)	362,000
Medical and surgical supplies	354,000	-	(20,000)	334,000
Other contracted services	1,218,000	-	(153,000)	1,065,000
Other	1,145,000	-	(52,000)	1,093,000
Amortization	495,000	-	-	495,000
TOTAL EXPENSES BY OBJECT	$ 11,994,000	$ (212,000)	$ 9,000	$ 11,791,000

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS FOR THE YEAR ENDED MARCH 31, 2011

Consolidated Statement of Operations

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
Revenue					
Alberta Health and Wellness contributions					
Unrestricted ongoing	$ 9,037,311	$ -	$ (459)	$ -	$ 9,036,852
Unrestricted deficit funding	527,235	-	-	-	527,235
Restricted	747,830	-	-	-	747,830
Other government contributions	100,893	(3,552)	(12,206)	16,670	101,805
Fees and charges	621,481	-	(194,423)	-	427,058
Ancillary operations	112,367	-	-	-	112,367
Donations	28,574	-	-	-	28,574
Investment and other income	292,119	-	(240)	(16,670)	275,209
Amortization of external capital contributions	364,181	-	-	-	364,181
TOTAL REVENUE	11,831,991	(3,552)	(207,328)	-	11,621,111
Expenses					
Inpatient acute nursing services	2,584,209	-	(5,682)	(10,841)	2,567,686
Emergency and other outpatient services	1,220,870	-	(1,053)	(3,409)	1,216,408
Facility-based continuing care services	844,753	(1,801)	(13,996)	612	829,568
Ambulance services	343,034	-	-	9,373	352,407
Community-based care	800,256	(1,751)	(203)	(537)	797,765
Home care	402,375	-	-	(227)	402,148
Diagnostic and therapeutic services	1,861,589	-	(4,321)	(1,744)	1,855,524
Promotion, prevention and protection services	289,508	-	56	(251)	289,313
Research and education	214,253	-	181	(7,411)	207,023
Administration	307,342	-	(5,666)	2,549	304,225
Information technology	387,655	-	(7)	-	387,648
Support services	1,521,754	-	(176,637)	11,886	1,357,003
Amortization of facilities and improvements	198,238	-	-	-	198,238
TOTAL EXPENSES	10,975,836	(3,552)	(207,328)	-	10,764,956
Operating surplus (deficiency) of revenue over expenses	$ 856,155	$ -	$ -	$ -	$ 856,155

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS (continued)
FOR THE YEAR ENDED MARCH 31, 2011

Consolidated Statement of Financial Position

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
ASSETS					
Current:					
Cash and cash equivalents	$ 1,721,465	$ -	$ -	$ (957,322)	$ 764,143
Investments	-	-	-	957,322	957,322
Accounts receivable	201,293	-	-	-	201,293
Contributions receivable from Alberta Health and Wellness	200,313	-	-	-	200,313
Inventories	99,097	-	-	-	99,097
Prepaid expenses	61,646	(2,700)	-	-	58,946
	2,283,814	(2,700)	-	-	2,281,114
Non-current cash and investments	599,335	-	-	-	599,335
Capital contributions receivable from Alberta Health and Wellness	11,476	-	-	-	11,476
Capital assets	6,707,464	-	-	-	6,707,464
Other assets	214,546	(130,953)	-	12,511	96,104
TOTAL ASSETS	$ 9,816,635	$ (133,653)	$ -	$ 12,511	$ 9,695,493
LIABILITIES AND NET ASSETS					
Current:					
Accounts payable and accrued liabilities	$ 1,136,937	$ -	$ -	$ -	$ 1,136,937
Accrued vacation pay	385,525	-	-	-	385,525
Deferred contributions	595,292	-	-	12,329	607,621
Current portion of long-term debt	153,799	-	-	-	153,799
	2,271,553	-	-	12,329	2,283,882
Deferred contributions	163,725	(151,396)	-	(12,329)	-
Deferred capital contributions	541,856	-	-	-	541,856
Long-term debt	182,500	-	-	-	182,500
Unamortized external capital contributions	5,598,973	-	-	-	5,598,973
Other liabilities	97,454	34,575	-	12,511	144,540
	8,856,061	(116,821)	-	12,511	8,751,751
Net assets:					
Accumulated surplus	115,741	(16,832)	-	-	98,909
Accumulated net unrealized gains (losses) on investments	(9,110)	-	-	-	(9,110)
Other internally restricted net assets	66,722	-	-	-	66,722
Internally restricted net assets invested in capital assets	777,071	-	-	-	777,071
Endowments	10,150	-	-	-	10,150
	960,574	(16,832)	-	-	943,742
TOTAL LIABILITIES AND NET ASSETS	$ 9,816,635	$ (133,653)	$ -	$ 12,511	$ 9,695,493

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS (continued)
FOR THE YEAR ENDED MARCH 31, 2011

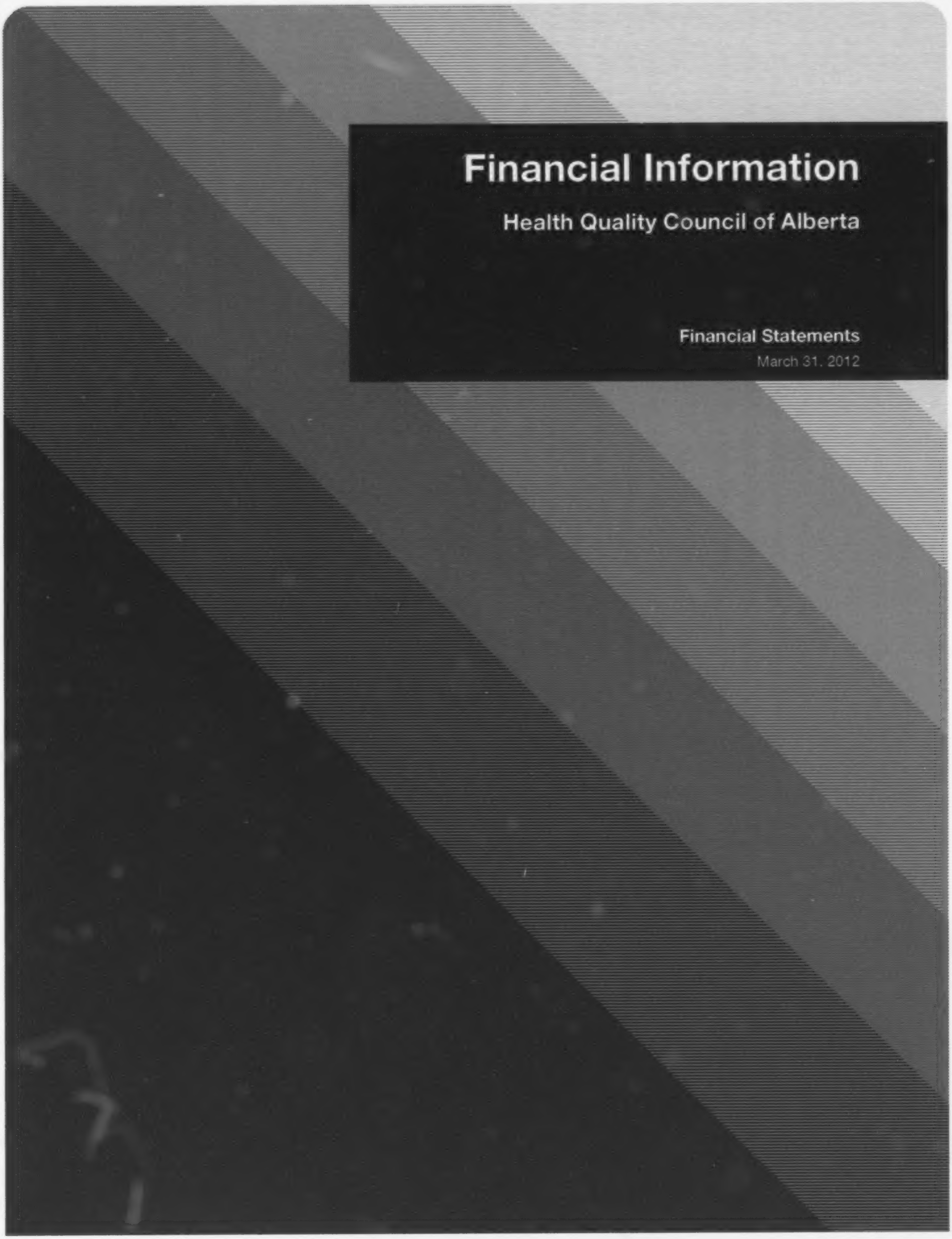
Consolidated Statement of Cash Flows

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
Operating activities:					
Operating surplus (deficiency) of revenue over expenses	$ 856,155	$ -	$ -	$ -	$ 856,155
Non-cash transactions:					
Amortization expense	470,511	-	-	-	470,511
Amortized external capital contributions	(364,606)	-	-	-	(364,606)
Other	(2,503)	(2,698)	-	52,706	47,505
Changes in non-cash working capital	(2,169)	2,698	-	(738,403)	(737,874)
Cash generated from (used by) operating activities	957,388	-	-	(685,697)	271,691
Cash generated from (used by) investing activities	(417,807)	-	-	(52,706)	(470,513)
Cash generated from financing activities	204,668	-	-	-	204,668
Net increase in current cash and cash equivalents	744,249	-	-	(738,403)	5,846
Current cash and cash equivalents, beginning of year	977,216	-	-	(218,919)	758,297
Current cash and cash equivalents, end of year	$ 1,721,465	$ -	$ -	$ (957,322)	$ 764,143

SCHEDULE 4 - CONSOLIDATED SCHEDULE OF RESTATEMENTS (continued)
FOR THE YEAR ENDED MARCH 31, 2011

Consolidated Schedule of Expenses by Object

	As Previously Reported	Long-term care Adjustment (Note 3(a))	Full cost Adjustment (Note 3(b))	Reclassifications (Note 3(d))	As Restated
Salaries and benefits	$ 5,667,428	$ -	$ -	$ -	$ 5,667,428
Contracts with health service providers	1,958,269	-	(207,328)	130,569	1,881,510
Contracts under the Heath Care Protective Act	19,308	-	-	-	19,308
Drugs and gases	361,468	-	-	-	361,468
Medical and surgical supplies	330,132	-	-	-	330,132
Other contracted services	1,112,310	-	-	(137,954)	974,356
Other	1,056,410	(3,552)	-	7,385	1,060,243
Amortization	470,511	-	-	-	470,511
TOTAL EXPENSES BY OBJECT	$ 10,975,836	$ (3,552)	$ (207,328)	$ -	$ 10,764,956



Financial Information

Health Quality Council of Alberta

Financial Statements

March 31, 2012

HEALTH QUALITY COUNCIL OF ALBERTA

FINANCIAL STATEMENTS

MARCH 31, 2012

Statement of Management Responsibility

Independent Auditor's Report

Statement of Financial Position

Statement of Operations

Statement of Changes in Net Assets

Statement of Cash Flows

Notes to the Financial Statements

Schedule 1 – Schedule of Expenses by Object

Schedule 2 - Schedule of Salaries and Benefits

Schedule 3 - Schedule of Related Party Transactions

Schedule 4 – Actual Financial Results Compared To Budget

HEALTH QUALITY COUNCIL OF ALBERTA

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

MARCH 31, 2012

The accompanying financial statements are the responsibility of management and have been reviewed and approved by Senior Management. The financial statements were prepared in accordance with Canadian Generally Accepted Accounting Principles, and of necessity, include some amounts that are based on estimates and judgement.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains a system of internal accounting controls comprising written policies, standards and procedures, a formal authorization structure, and satisfactory processes for reviewing internal controls. This system provides management with reasonable assurance that transactions are in accordance with governing legislation and are properly authorized, reliable financial records are maintained, and assets are adequately safeguarded.

The Health Quality Council of Alberta's Board of Directors carries out their responsibility for the financial statements through the Audit and Finance Committee. The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the financial statements to the Health Quality Council of Alberta Board of Directors for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Audit and Finance Committee.

The Auditor General of Alberta provides an independent audit of the financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures, which allow him to report on the fairness of the financial statements prepared by management.

[original signed by]

Chief Executive Officer
Dr. John Cowell
June 6, 2012

[original signed by]

Executive Director
Charlene McBrien-Morrison
June 6, 2012

AUDITOR
GENERAL
Alberta

Independent Auditor's Report

To the Board of Directors of the Health Quality Council of Alberta

Report on the Financial Statements

I have audited the accompanying financial statements of the Health Quality Council of Alberta, which comprise the statement of financial position as at March 31, 2012, and the statements of operations, changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the financial statements present fairly, in all material respects, the financial position of the Health Quality Council of Alberta as at March 31, 2012, and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

[Original signed by Merwan N. Saher, FCA]

Auditor General

June 6, 2012

Edmonton, Alberta

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF FINANCIAL POSITION
AS AT MARCH 31, 2012
(in thousands)

	2012 Actual	2011 Actual
Assets		
Current		
Cash	$ 781	$ 1,463
Accounts receivable	131	38
Contributions receivable from Alberta Health and Wellness	-	1,000
Prepaid expenses	65	5
Capital assets (Note 3)	229	61
Total Assets	$ 1,206	$ 2,567
Liabilities and Net Assets		
Liabilities		
Accounts payable and accrued liabilities	$ 628	$ 575
Accrued vacation pay	123	107
Deferred contributions (Note 4)	-	1,000
	751	1,682
Net Assets		
Accumulated surplus	226	824
Investment in capital assets	229	61
	455	885
Total Liabilities and Net Assets	$ 1,206	$ 2,567

The accompanying notes and schedules are part of these financial statements.

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF OPERATIONS
FOR THE YEAR ENDED MARCH 31, 2012
(in thousands)

	2012		2011
	Budget	Actual	Actual
Revenue			
Alberta Health and Wellness - global funding	$ 4,026	$ 4,026	$ 4,431
Alberta Health and Wellness - restricted funding	1,000	955	207
Investment and other income	115	139	39
	5,141	5,120	4,677
Expenses (Schedule 1)			
Administration and program expenses	5,845	5,344	4,338
Information technology	117	206	100
	5,962	5,550	4,438
Excess (deficiency) of revenue over expenses	$ (821)	$ (430)	$ 239

The accompanying notes and schedules are part of these financial statements.

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CHANGES IN NET ASSETS
FOR THE YEAR ENDED MARCH 31, 2012
(in thousands)

	2012			2011		
	Accumulated surplus	Investment in capital assets	Total	Accumulated surplus	Investment in capital assets	Total
Opening net assets	$ 824	$ 61	$ 885	$ 613	$ 33	$ 646
Excess (deficiency) of revenue over expenses	(430)	-	(430)	239		239
Purchase of capital assets	(217)	217	-	(63)	63	-
Amortization of capital assets	49	(49)	-	35	(35)	-
Closing net assets	$ 226	$ 229	$ 455	$ 824	$ 61	$ 885

The accompanying notes and schedules are part of these financial statements.

HEALTH QUALITY COUNCIL OF ALBERTA
STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED MARCH 31, 2012
(in thousands)

	2012	2011
Operating Transactions		
Excess (deficiency) of revenue over expenses	$ (430)	$ 239
Non-cash items:		
Amortization of capital assets	49	35
	(381)	274
Changes in non-cash in working capital items		
(Increase)decrease in accounts receivable	(93)	10
Decrease (increase) in contributions receivable from Alberta Health and Wellness	1,000	(1,000)
(Increase) in prepaid expenses	(60)	(1)
Increase in accounts payable and accrued liabilities	53	347
Increase in accrued vacation payable	16	1
(Decrease) increase in deferred contributions	(1,000)	192
Cash applied to operating transactions	(465)	(177)
Cash (used) by investing activities		
Acquisition of capital assets	(217)	(63)
Cash applied to investing activities	(217)	(63)
Decrease in cash	(682)	(240)
Cash at beginning of year	1,463	1,703
Cash at end of year	$ 781	$ 1,463

The accompanying notes and schedules are part of these financial statements

Note 1 Authority, Purpose and Operations

Effective February 1, 2012 the *Health Quality Council of Alberta Act* came into force and the *Health Quality Council of Alberta Regulation (130/2006)* was repealed.

The Health Quality Council of Alberta (HQCA) was established under the *Health Quality Council of Alberta Regulation (130/2006)* and is continued as a corporation under the *Health Quality Council of Alberta Act*.

Pursuant to the *Health Quality Council of Alberta Act*, the Health Quality Council of Alberta has a mandate to promote and improve patient safety and health service quality on a province-wide basis.

The Health Quality Council of Alberta is considered a not-for-profit entity and is exempt from Canadian federal and Alberta provincial income taxes.

Note 2 Summary of Significant Accounting Policies and Reporting Practices

These financial statements are prepared in accordance with Canadian generally accepted accounting principles.

(a) Basis of Financial Reporting

Revenue

The financial statements have been prepared using the deferral method of accounting for contributions. The key elements of the HQCA's revenue recognition polices are: (1) all revenues are reported on the accrual basis of accounting; (2) unrestricted contributions are recognized as revenue in the year received or receivable if the amount can be reasonably estimated and collection is reasonably assured; (3) restricted contributions are deferred and recognized as revenue in the year the related expenses are incurred.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(a) Basis of Financial Reporting, continued

Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year is expensed.

Grants are recognized as expenses when authorized, eligibility criteria if any are met, and a reasonable estimate of the amounts can be made.

Capital Assets

Capital assets are reported at cost less accumulated amortization. Asset purchases valued at $5,000 or greater are recorded as a capital asset. Amortization is recorded on a straight line basis at rates based on the estimated useful lives of the capital assets as follows:

	Useful Life
• Computer equipment	2 years
• Information systems	3 years
• Office equipment	3 years
• Leasehold improvements	Over term of lease

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(b) Financial Instruments

The HQCA has classified its financial assets and financial liabilities as held-for-trading. Financial assets and liabilities classified as held-for-trading are measured at fair value with changes in their value (unrealized gains or losses) recorded in the Statement of Operations. Unrealized gains or losses from changes in fair value or realized gains or losses on disposal are accounted for as investment income. Any interest earned (or incurred) is recognized on an accrual basis as interest income (or expense).

(c) Measurement Uncertainty

The financial statements, by their nature, contain estimates and are subject to measurement uncertainty. The amounts recorded for amortization of capital assets are based on estimates of the useful life of the related assets. Actual results could differ from estimates.

(d) Employee Future Benefits

The HQCA participates in the Local Authorities Pension Plan (LAPP). This multi-employer defined benefit pension plan provides pensions for participating employees based on years of service and earnings. The Minister of Finance is the legal trustee and administrator of the plan. The Department of Finance accounts for the liabilities for pension obligations as a participating employer for former and current employees in Local Authorities Pension Plan for all of the organizations included in the Government of Alberta (GOA) consolidated reporting entity except for government business enterprises. As the HQCA is included in the GOA consolidated reporting entity the HQCA follows the standards for defined contribution accounting for this pension plan. Accordingly, the pension expense recorded for this plan in these financial statements is comprised of the employer contributions that the HQCA is required to pay for its employees during the fiscal year.

Note 2 Summary of Significant Accounting Policies and Reporting Practices (continued)

(e) Changes to Accounting Framework

The Public Sector Accounting Board (PSAB) has issued a financial reporting framework for government not-for-profit organizations using Public Sector Accounting (PSA) standards effective for fiscal years beginning on or after January 1, 2012. Effective April 1, 2012, the HQCA will adopt these standards without the PS 4200 series. As a result, management is determining the impact on its March 31, 2013 financial statements and is developing a transition plan to adopt the full scope of the PSA standards for the next fiscal year. The March 31, 2013 financial statements will reflect comparative financial information also prepared in accordance with PSA standards.

Note 3 Capital Assets

	2012				2011
	Equipment	Computer hardware & software	Other[a]	Total	Total
Historical Cost					
Beginning of year	$ 31	$ 261	$ 27	$ 319	$ 256
Additions	79	120	18	217	63
	110	381	45	536	319
Accumulated Amortization					
Beginning of year	31	215	12	258	223
Amortization expense	-	41	8	49	35
	31	256	20	307	258
Net book value at March 31, 2012	$ 79	$ 125	$ 25	$ 229	
Net book value at March 31, 2011	$ -	$ 46	$ 15		$ 61

(a) Other capital assets include leasehold improvements.

HEALTH QUALITY COUNCIL OF ALBERTA
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2012
(in thousands)

Note 4 Deferred Contributions

The balance at the end of the year is restricted for the following purposes:

	2012	2011
Current		
Ministerial Review	$ -	$ 1,000

Note 5 Employee Benefit Plan and Pension Expense

Pension expense recorded in the financial statements is equivalent to the HQCA's annual contribution of $167 for the year ended March 31, 2012 (2011: $132).

At December 31, 2011, the Local Authorities Pension Plan reported a deficiency of $4,639,390 (2010 deficiency of $4,635,250).

Note 6 Contractual Obligations

Contractual obligations are obligations of the HQCA to others that will become liabilities in the future when the terms of those contracts or agreements are met.

	2012	2011
Obligations under operating leases, contracts and programs	$ 2,152	$ 2,657

Estimated payment requirements for each of the next four (4) years and thereafter are as follows:

2012-2013	$ 819
2013-2014	776
2014-2015	495
2015-2016	62
Thereafter	-
	$ 2,152

A lease agreement is in place for July 1, 2011 to June 30, 2016 for office space in Calgary. This commits the HQCA to annual rent in the amount of $137 and operating & realty tax expense recoverable by the landlord, subject to adjustment in accordance with the lease, of approximately $108 annually.

The HQCA signed a 5 year lease ending August 31, 2013 for office space in Edmonton with annual rent in the amount of $47 and operating & realty tax expense recoverable by the landlord, subject to adjustment in accordance with the lease of approximately $27 annually.

The HQCA has a commitment with Dr. John W. Cowell Consulting Ltd. to receive executive oversight. The value of the commitment as at March 31, 2012 is $42 per month and extends until September 2014.

HEALTH QUALITY COUNCIL OF ALBERTA
NOTES TO THE FINANCIAL STATEMENTS
MARCH 31, 2012
(in thousands)

Note 7 Budget

The budget was approved by the HQCA Council on June 9, 2011, and submitted to the Minister of Health and Wellness.

Note 8 Approval of Financial Statements

The financial statements were approved by the HQCA Board of Directors on June 6, 2012.

Schedule 1

HEALTH QUALITY COUNCIL OF ALBERTA
EXPENSES DETAILED BY OBJECT
FOR THE YEAR ENDED MARCH 31, 2012
(in thousands)

	2012		2011
	Budget	Actual	Actual
Salaries and benefits	$ 2,485	$ 2,563	$ 2,337
Office, general supplies, miscellaneous	594	601	454
Referred-out services	2,305	1,686	1,092
Grants	58	136	103
Lease, fees and minor equipment	372	309	317
System support	117	206	100
Amortization of capital assets	31	49	35
	$ 5,962	$ 5,550	$ 4,438

Schedule 2

HEALTH QUALITY COUNCIL OF ALBERTA
SALARY AND BENEFITS DISCLOSURE
FOR THE YEAR ENDED MARCH 31, 2012
(in thousands)

	2012				2011
	Base Salary [1]	Other Cash Benefits [2]	Other Non-Cash Benefits [3]	Total	Total
Board of Directors-Chair	$ -	$ 23	$ -	$ 23	$ 20
Board of Directors-Members	-	42	-	42	47
Chief Executive Officer [4]	482	33	1	516	485
Executive Director	145	10	26	181	178

Prepared in accordance with Treasury Board Directive 12/98 as amended.

(1) Base salary includes pensionable base pay.

(2) Other cash benefits include bonuses and honoraria.

(3) Other non-cash benefits include:

(a) Share of all employee benefits and contributions or payments made on behalf of employees, including pension, health care, dental coverage, vision coverage, out of country medical benefits, group life insurance, accidental disability and dismemberment insurance, long and short-term disability plans, employee assistance program and employment insurance.

(4) Chief Executive Officer is retained through an eight (8) year executive oversight contract, which holds HQCA harmless of any related overtime, supplementary retirement, and benefits other than medical reimbursement and variable pay which is subject to the approval of the Board of Directors.

HEALTH QUALITY COUNCIL OF ALBERTA
RELATED PARTY TRANSACTIONS
FOR THE YEAR ENDED MARCH 31, 2012
(in thousands)

Related parties are those entities consolidated or accounted for on a modified equity basis in the Province of Alberta's financial statement.

The Health Quality Council of Alberta had the following transactions with related parties recorded in the Statement of Operations and the Statement of Financial Position at the amount of consideration agreed upon between the related parties.

	2012	2011
Revenue		
Alberta Health and Wellness-global funding	$ 4,026	$ 4,431
Alberta Health and Wellness-restricted funding	955	207
Alberta Health Services-restricted funding	107	-
Alberta Health Services - recovery of services	7	11
	$ 5,095	$ 4,649
Expense		
Alberta Health Services-contracted services	$ -	$ 12
Service Alberta	3	8
	$ 3	$ 20
Receivable from		
Alberta Health Services	$ 101	$ 1
Payable to		
Alberta Health Services	$ -	$ 12

Schedule 4

HEALTH QUALITY COUNCIL OF ALBERTA
BUDGET
FOR THE YEAR ENDED MARCH 31, 2012
(in thousands)

	Actual	Budget	Variance
Revenue			
Alberta Health and Wellness-global funding	$ 4,026	$ 4,026	$ -
Alberta Health and Wellness-restricted funding	955	1,000	(45)
Investment and other income	139	115	24
	5,120	5,141	(21)
Expense			
Salaries and benefits	2,563	2,485	78
Referred-out services	1,686	2,305	(619)
Office, general supplies, miscellaneous	601	594	7
Lease, fees and minor equipment	309	372	(63)
System support	206	117	89
Grants	136	58	78
Amortization of capital assets	49	31	18
	5,550	5,962	(412)
Deficiency of revenue over expenses	$ (430)	$ (821)	$ (391)

Ministry Contacts

For further information regarding the contents of this annual report, please contact:

Position	Name	Phone Number
Minister of Health and Wellness	Fred Horne	780.427.3665 Fax: 780.415.0961
Deputy Minister of Health and Wellness	Marcia Nelson	780.422.0747 Fax: 780.427.1016
Community and Population Health Assistant Deputy Minister	Margaret King	780.415.2783 Fax: 780.422.3671
Corporate Support Assistant Deputy Minister	Martin Chamberlain	780.422.1045 Fax: 780.422.3672
Financial Accountability Assistant Deputy Minister	David Breakwell	780.415.1599 Fax: 780.422.3672
Health Policy and Service Standards Assistant Deputy Minister	Susan Williams	780.644.3086 Fax: 780.415.0570
Health Information Technology and Systems Assistant Deputy Minister and Chief Information Officer	Mark Brisson	780.427.1572 Fax: 780.422.5176
Health Workforce Assistant Deputy Minister	Glenn Monteith	780.415.2745 Fax: 780.415.8455
Policy and Issues Coordination Assistant Deputy Minister	Linda Mattern	780.422.2720 Fax: 780.427.1016
Chief Medical Officer of Health	Dr. James Talbot	780.415.2809 Fax: 780.427.7683
Communications Director	Andy Weiler	780.427.5344 Fax: 780.427.1171
Human Resources Executive Director	Rick Brick	780.427.1060 Fax: 780.422.1700